State of Indiana

IPAS & PASRR Program Manual

January, 2000

Indiana's PreAdmission Screening

and

PreAdmission Screening and Resident Review

Family and Social Services Administration

Division of Disability, Aging, and Rehabilitative Services

Bureau of Aging and In-Home Services

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IPAS/PASARR Program Manual
Transmittal #3

SECTION	PAGES		DESCRIPTION
	NEW	OLD	
Manual Issuance: 1/30/96	Section 100, 200, Appendices	NA	Issuance of IPAS/PASARR Program Manual
New Section 210: Resident Review Issued 7/1/97	65-78n*	65-78	Changes process for PASARR Resident Review (RR) in compliance with P.L. 104-315, effective 7/1/97. This Section was issued and distributed as Medicaid Bulletin E97-21, dated August 15, 1997. Note: *Pages 76-78 were inadvertently deleted when font size was reduced for printing as a Medicaid Bulletin. The chart on page 68a is no longer applicable.
Revised Manual Issuance: 01/01/00	New Chapters 1 – 19, Glossary, and Appendices	NA	Entire Manual revised, reformatted, and reissued.

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IPAS/PASARR Program Manual

INTRODUCTION

Introduction, Purpose and Scope, Design,
Use and Distribution
of the IPAS/PASARR Program Manual

Introduction

Indiana's state-required PreAdmission Screening (IPAS) and the federal PreAdmission Screening and Annual Resident Review (PASARR) programs are administered by Indiana's Family and Social Services Administration (FSSA), Division of Disability, Aging and Rehabilitative Services (DDARS), Bureau of Aging and In-Home Services (BAIHS) working in coordination with the Office of Medicaid Policy and Planning (OMPP) and the Division of Mental Health (DMH).

At the local level, these programs are operated by the 16 Area Agencies on Aging (AAA) acting as the designated IPAS agencies, the 30 Community Mental Health Centers (CMHCs), and the eight (8) Bureau of Developmental Disabilities Services (BDDS) offices working with the five (5) Diagnostic and Evaluation (D&E) Teams. All Indiana licensed nursing facilities (NFs) and hospitals are also involved in this operation.

Purpose and Scope of the Manual

This manual provides instructions and procedures for determining eligibility for admission to and/or continued residence in state licensed and/or Medicaid certified nursing facility (NF) beds in Indiana. These instructions are in compliance with State and Federal laws and regulations governing the IPAS and PASARR programs. Also included are the procedures to be followed by IPAS Agencies, NFs, hospitals, CMHCs, BDDS Field Offices, D&E Teams and other involved entities to administer and comply with applicable laws and regulations. This Manual is maintained in both hard copy and electronic versions (Word Perfect). To obtain it on diskette, please provide two (2) blank diskettes to the Division.

Design

The manual is designed in an expanded outline format that contains four (4) Sections: Introduction; Program Section 100 - IPAS Procedures; Program Section 200 - PASARR Procedures; and Appendices. Each Section is subdivided by chapters, and each chapter is preceeded by a Table of Contents. The Appendix Section at the end contains a listing of program acronyms and definitions, other addendums, program forms (in order of usage), and an index.

All requirements in this manual are based on State and/or Federal laws and regulations. The manual itself is not promulgated.

Manual Updates

When required, numbered Manual Transmittal Bulletins/Letters will be used to transmit hard copies of new or revised manual material and updated pages. Each Letter will have a "transmittal number" which is to be recorded, along with the date of issuance, on the attached list of Manual Transmittal Letters. Obsolete material should then be removed and replaced by the new/revised material as directed in the Transmittal Letter. KEEP YOUR COPY OF THE MANUAL CURRENT OR IT IS USELESS. Contact your local IPAS Agency with questions concerning manual updates or to obtain missing material.

Use

The program manual is the primary tool for program operation and compliance. As with any tool, skilled use comes with both training and experience. Contact your local IPAS agency with questions or additional training requests.

Use the Tables of Contents to locate general topics and the Index to find specific items. Once material is located, read the entire text regarding the topic.

Distribution

Initial distribution of the IPAS/PASARR Program Manual is made to the 16 IPAS Agencies (AAAs) which will distribute copies to local NFs, hospital Social Work Departments, CMHC OBRA/PASARR contact persons, BDDS Integrated Field Services offices, D&E Teams and other involved entities. When additional copies of the manual are needed, the local IPAS Agency is to notify the State PASARR Program at the BAIHS, DDARS, which maintains the distribution list.

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Chapter 1

INTRODUCTION

1.1 PROGRAM BASIS

Indiana's PreAdmission Screening Program (IPAS) was created by Public Law 21, Acts of 1982. It was implemented statewide on April 30, 1983. Indiana Code (IC) 12-10-12 and 460 Indiana Administrative Code 460 (IAC) 1-1 codify the law and rules under which IPAS operates.

PAS is administered by the Bureau of Aging and In-Home Services (BAIHS) of the Division of Disability, Aging, and Rehabilitative Services (DDARS) of the Indiana Family and Social Services Administration (FSSA) through the 16 Area Agencies on Aging, designated as IPAS agencies.

NOTE: To avoid confusion with the preadmission screening (PAS) function of the "PASRR" program, Indiana's PreAdmission Screening program will be identified as "IPAS."

1.2 GOAL AND PURPOSE OF IPAS

The goal of IPAS is to prevent premature or unnecessary placement in a nursing facility (NF) of individuals whose long-term care needs do not require NF level of services or can be more appropriately met through in-home and community-based services. IPAS provides the opportunity for the provision of long-term care services in a location conducive to the physical and psychological well-being of an individual.

The objectives of IPAS are:

- to identify individuals who are "at-risk" of institutionalization and meet the state's criteria for NF placement;
- to provide a comprehensive assessment of an individual's needs;
- to ascertain whether alternative services are available in the community that would be more appropriate than care in a NF at not more than the cost of placement in a NF;
- to deny entrance to a NF when the criteria are not met, unless an individual is willing to forego eligibility for Medicaid reimbursement for NF per diem costs for a period of up to one year from the date of admission to a NF; and
- to meet the requirements of the PAS-portion of Indiana's PASRR program.

1.3 RELATIONSHIP OF IPAS TO PASRR

The federal PreAdmission Screening and Resident Review (PASRR) program is required to interface with existing or future nursing facility (NF) preadmission screening and resident assessment procedures to the greatest extent possible.

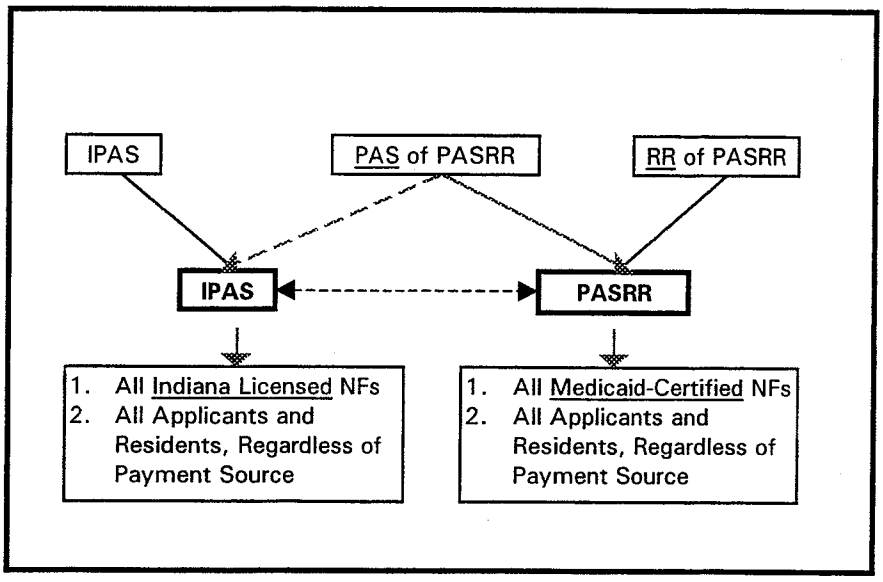
Through its Medicaid State Plan, Indiana incorporates and utilizes Indiana's IPAS program in the PASRR process. IPAS thus provides the following functions for the PAS portion of the PASRR program:

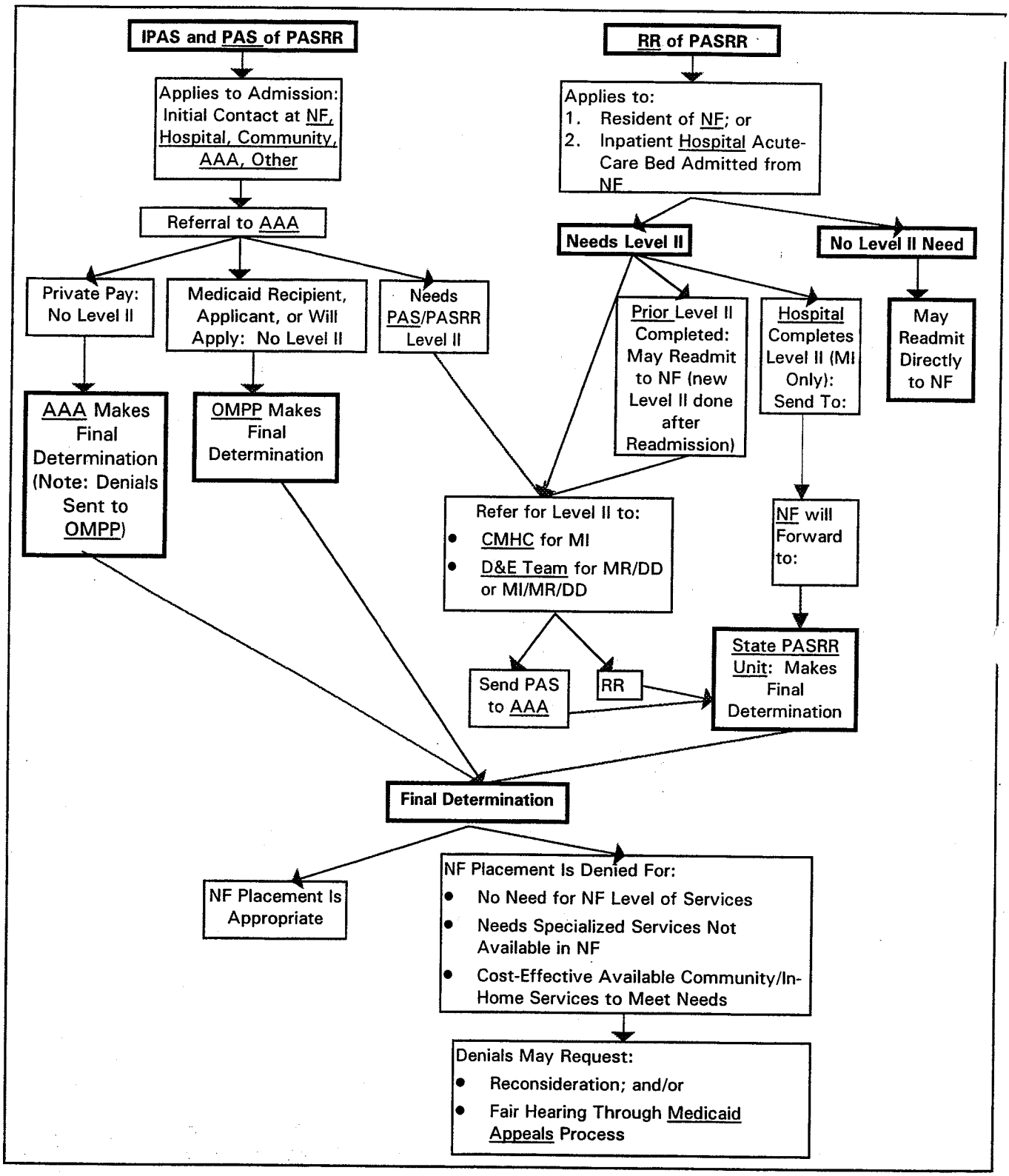
- identification of persons seeking admission to Medicaid certified NFs;
- review and certification of need for the Level II assessment on the Level I form;
- written notice to the individual of referral for Level II;
- activation mechanism to complete a Level II assessment to the CMHC or D&E Team;
- provision of necessary data to evaluate and determine need for NF level of care including physical status, functional assessment (activities of daily living), alternative services and/or placement;
- liaison between NF, family, physician, and other entities as necessary;
- review of documentation and recommendation for placement;
- coordinating entity to compile PAS case documents for submission to the State;
- entity to disseminate information and procedural directions including linkage with the State PASRR program; and

- distribution, retention, and preservation of case records.

For information and procedures for Indiana's PASRR program, see Chapters 10-16 of this Program Manual.

INTERRELATIONSHIP OF IPAS AND PASRR
Chapter 1




IPAS and PAS of PASRR
Applies to Admission: Initial Contact at NF, Hospital, Community, AAA, Other
Referral to AAA
Private Pay: No Level II
Medicaid Recipient, Applicant, or Will Apply: No Level II
Needs PAS/PASRR Level II
AAA Makes Final Determination (Note: Denials Sent to OMPP)
OMPP Makes Final Determination
RR of PASRR
Applies to:
1. Resident of NF; or
2. Inpatient Hospital Acute-Care Bed Admitted from NF
Needs Level II
No Level II Need
Prior Level II Completed: May Readmit to NF (new Level II done after Readmission)
Hospital Completes Level II (MI Only): Send To:
May Readmit Directly to NF
Refer for Level II to:
• CMHC for MI
• D&E Team for MR/DD or MI/MR/DD
NF will Forward to:
Send PAS to AAA
RR
State PASRR Unit: Makes Final Determination
Final Determination
NF Placement Is Appropriate
NF Placement Is Denied For:
• No Need for NF Level of Services
• Needs Specialized Services Not Available in NF
• Cost-Effective Available Community/In-Home Services to Meet Needs
Denials May Request:
• Reconsideration; and/or
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  - 2.8.4.3 Direct from Hospital Admissions

2.9 NF TRANSFER AND READMISSION

2.10 HOSPITAL-BASED NF UNITS

Chapter 2

IPAS APPLICATION AND LEVEL I

Indiana Code (IC) 12-10-12 prohibits an Indiana NF licensed under IC 16-28 from admitting or retaining any individual without complying with IPAS program requirements. (See Chapters 1-9.) If the NF is Medicaid-certified, PASRR program requirements also apply. (See Chapters 10-18.)

2.1 PARTICIPATION REQUIREMENTS

IC 12-10-12 places the responsibility on the NF to assure that all admissions and NF stays are in compliance with applicable IPAS and PASRR laws and regulations. NFs should contact the local IPAS agency if there are questions.

2.1.1 Indiana Licensed NFs

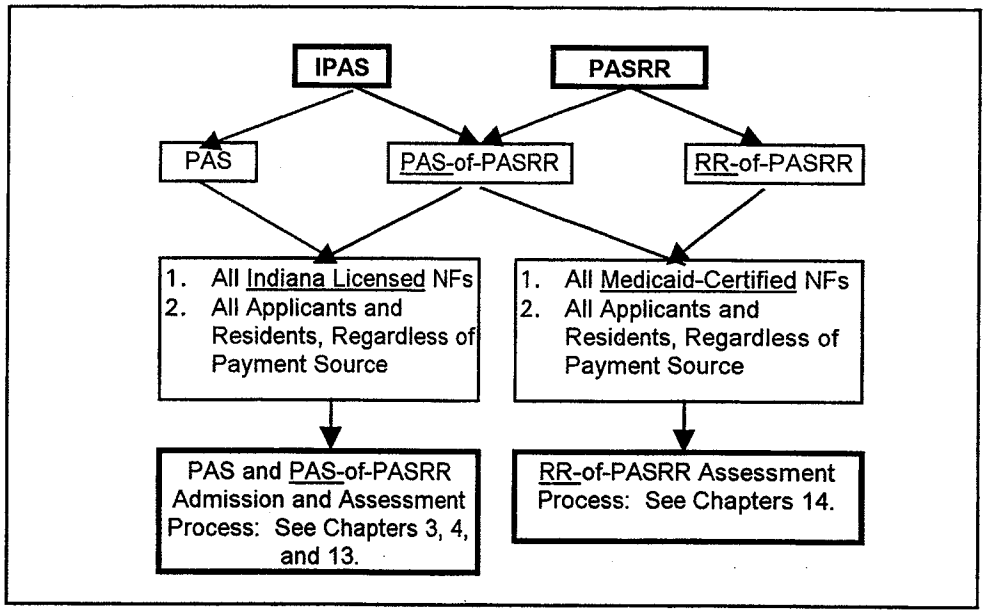
Every nursing facility (NF) operating in Indiana which provides NF comprehensive-care level of services must be licensed. Medicaid and/or Medicare may also certify a NF to provide NF level of services.

a) "Free standing" NF beds are licensed under IC 16-28-2 (long-term care).
b) "Hospital-based" NF beds may be licensed either under IC 16-21-2 (hospital) or IC 16-28-2 (long-term care), according to the facility's or unit's administrative structure.

In Indiana, every NF licensed under IC 16-28-2 must participate in the IPAS program. (See Chapter 3.10 for IPAS requirements for hospital-based NF units.)

To verify licensure status, refer to the Indiana Health Facilities Directory, published annually by the Indiana State Department of Health (ISDOH). Free-standing NFs are listed in the main section of the Directory. Hospital-based hospital-licensed NFs (licensed under IC 16-21-2) are listed in a separate section at the back of the Directory.

IPAS PARTICIPATION REQUIREMENTS
Chapter 2.1



2.1.2 Applicant

For IPAS and PASRR purposes, a PAS applicant is an individual seeking either temporary or long-term admission to an Indiana licensed NF.

ALL applicants are required to participate in IPAS, regardless of the source or method of NF payment which will be used. "Regardless of source or method of payment" includes such sources of payment as Medicare, Medicaid, VA contract, insurance, private-pay, and any other means of payment for a stay in any NF.

Refusal to participate, with admission to the NF or continued residence in a NF after an IPAS denial, will result in an IPAS penalty for the individual. (See Chapter 6.2 of this Manual.)

2.1.2.1 "Grandparent" Provision

Individuals are exempted from the IPAS requirements set out in IC 12-10-12 if they were:

a) admitted to a NF prior to implementation of the IPAS program on April 30, 1983; and
b) have not been discharged to a community-based or other institutional living arrangement.

When a resident who qualifies under the "grandparent" provision requests Medicaid reimbursement, the NF will clearly document to OMPP why the individual was exempted from IPAS, including the date of original NF admission.

NOTE: "Grandparented" residents are not exempted from compliance with RR provisions under PASRR.

2.1.2.2 State Psychiatric Hospital Resident

Regardless of the responses on PASRR Level I (including the "Dementia Exclusion"), ALL residents of State psychiatric hospitals must participate in a full PASRR Level II assessment and determination PRIOR to any NF admission.

2.1.2.3 Nonresident

See Chapter 3.8 for requirements and procedures.

2.2 "NEW ADMISSION"

IPAS participation is required for each "new admission" to a NF. For IPAS purposes, situations that require assessment may be, but are not limited to:

a) first-time admission to an Indiana NF; or
b) new admission following discharge to an alternative (non-NF) living arrangement; or
c) residence under the following circumstances:
    1. never notified of the IPAS requirement; or
    2. under IPAS penalty but qualifies as "SNF level of care" and applying for relief of the remainder of the penalty period. (See Chapter 6.2.)

The IPAS agency will always research the IPAS status of each applicant before processing the Application form. This includes a review of agency records, questioning the NF, applicant, family, and/or representative, and identifying past NF admission history for the applicant. (Also see Chapter 2.4.)

2.2.1 IPAS Required

IPAS assessment is required for:

a) initial admission to a NF;
b) admission after NF discharge to a community-living arrangement for a period of more than 24-hours;
c) NF residence without notification of IPAS requirements (completion of Application form, etc.), regardless of the length of NF residence; and
d) admission requiring PASRR Level II assessment. (See Chapter 10.3.4.)

NOTE: IPAS participation is required regardless of Medicare reimbursement status or Medicaid "15-day bed-hold" policy.

2.2.2 IPAS NOT Required

The IPAS agency will NOT process IPAS assessment for the following situations, regardless of the number of Application forms completed:

a) individuals currently being assessed for IPAS (see Chapter 2.4.1);
b) residents under IPAS penalty, unless the individual has a need for the level of NF services characterized as SNF under Indiana's Medicaid Rule (see Chapter 6.2);
c) readmissions to the same or a different NF, regardless of hospitalizations or therapeutic leaves which exceeded the Medicaid "15-day bed-hold limit" (see Chapter 2.4.5); and
d) transfers between NFs (see Chapter 2.9).

2.3 FORMS FOR IPAS/PASRR APPLICATION

Application for participation in IPAS is the first step in the IPAS (and PAS/PASRR) process.

2.3.1 NF "Notice to Applicant"

The IPAS Program Information sheet was developed to assist the NF in this task. (See Chapter 2.3.3.) The NF must:

a) notify every individual applying for admission, in writing, of the IPAS requirements; and
b) provide the IPAS Information Sheet; and
c) have the individual complete the Level I; and
d) assure that the IPAS Application form is completed.

Failure to follow admission requirements, including notification and completion of the IPAS Application constitutes a Class A infraction by the NF. (See Chapter 6.3.)

The IPAS Notice by the NF must include the following information:

1. every applicant for NF admission is required by state law to apply for participation in the IPAS program; and
2. the applicant's failure to participate in IPAS could result in the applicant's ineligibility for Medicaid reimbursement for per diem in any Indiana licensed NF for up to one (1) year (See Chapter 113); and
3. the IPAS program consists of an assessment of the applicant's need for nursing care in a NF made by a team of professionals familiar with the needs of individuals seeking admission to nursing facilities.

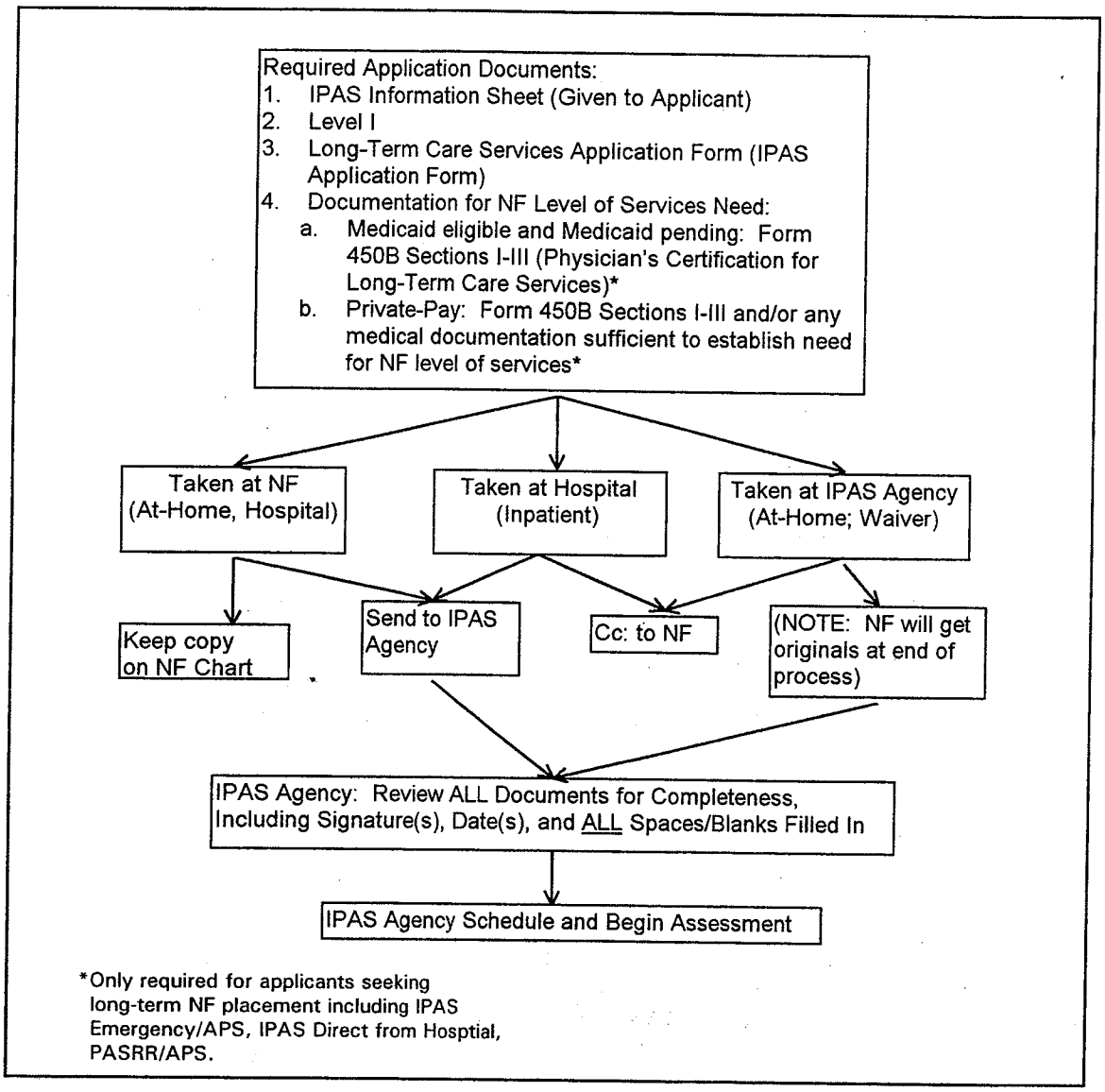
2.3.2 Forms for Application

The "complete" IPAS Application consists of the:

a) IPAS Program Information Sheet (See Appendix K); and
b) "Application for Long-Term Care Services" form (See Appendix L), herein referred to as the "IPAS Application;" and
c) Level I: Identification Evaluation Criteria screen, completed in conjunction with the Application, to identify need for Level II (See Appendix U); and
d) for designee-authorized long-term admissions, Physician Certification for Long-Term Care on the Form 450B, Sections I-III (See Appendix M); and
e) for MR/DD applicants, Physician Certification for Long-Term Care Services(Physical Examination for PASRR Level II), Form 450B, Section VI.

The NF must assure that an applicant (or the applicant's parent, guardian, or legal representative) has completed and signed the Application for Long-Term Care Services (IPAS Application) form:

a) PRIOR to admission; or
b) within twenty-four hours following admission for non-PASRR, IPAS designee-authorized, admissions. (See Chapter 3.)



The NF will review the application forms PRIOR to forwarding them to the IPAS agency to assure appropriate completion. All necessary portions of the IPAS Application and Level I forms will be completed before the IPAS Eligibility Screen can be initiated.

NOTE: When a resident is transferred to another NF, the Application packet and pertinent IPAS and/or PASRR documents must be forwarded by the discharging NF to the admitting NF in a timely manner. (See Chapter 3.9.)

2.3.3 IPAS Program Information Sheet

The IPAS Information Sheet explains the requirement to participate in IPAS, the program's intent and process, and the penalty for non-participation. (See Appendix K.) It is given to the individual or his or her legal representative when an inquiry is made regarding NF admission. Use of the IPAS Information Sheet assures that the applicant has received the information which the law requires the NF to provide. (See Chapter 2.3.1.)

2.3.4 Application Completion

When the NF finds that it is probable that the individual will enter the facility, the NF will have an IPAS Application form completed. (To avoid unnecessary assessments, casual inquiries are not referred for application.)

2.3.4.1 At NF

It is the responsibility of the NF to:

a) assure that the individual has made an informed decision;
b) assure that the form is completely filled out; and
c) provide verification that application for IPAS was made in a timely manner.

An "IPAS Application" form (Long-Term Care Services Application) is completed until all applicable items have been entered, and it is signed and dated. An incomplete IPAS Application will be returned to the NF for completion. Applicable receipt and return dates will be clearly stamped and documented on the IPAS Application form by the IPAS agency. An explanation should also be included in the case narrative.

It is the responsibility of the NF or, if completed at the hospital, of the hospital discharge planner to assist the applicant and/or his/her legal representative to complete the application process.

2.3.4.2 At Hospital

The Application form may be partially completed at the hospital for "Direct From Hospital" designee authorized temporary admissions. (See Chapter 3.7.3.2.)

2.3.4.3 At Home

The Application form may be completed in the applicant's home with the assistance of the IPAS agency's care manager or IPAS assessor. When acting in this role, the care manager or assessor must follow the same procedures as required of the NF. If a NF has been selected by the applicant, the care manager or assessor must assure that it receives a copy of the completed Application form and Level I in a timely manner.

2.3.5 Signature

The following protocol will be followed for signature on the IPAS Application form:

a) applicant;
b) parent, guardian, or health care power of attorney when the applicant is a minor or has been adjudicated legally incompetent;
c) health care representative appointed by the applicant;
d) applicant's spouse;
e) applicant's adult child;
f) applicant's adult sibling;
g) applicant's religious superior, if the applicant is a member of a religious order;
h) the person allowed to sign papers for hospital care and services or for NF placement and services;
i) any other person acting on behalf of and in the best interest interest of the applicant, and in the absence of a conflict of interest; or
j) the NF administrator, as a last resort, if there is a statement regarding the reason other choices are not available and a conflict of interest does not exist.

An individual signing on behalf of the applicant must have sufficient knowledge of the applicant's situation and condition to be able to answer questions pertaining to the Application form and the PASRR Level I screen.

2.3.6 Transmittal and Retention

The NF will:

1. give a copy of the completed Application form to the applicant;

2. retain one (1) signed copy of the Application form on file for at least one (1) year; and
3. deliver the original signed copy of the IPAS Application form and Level I (and, if applicable, the Form 450B) to the IPAS agency serving the county in which the applicant resides.

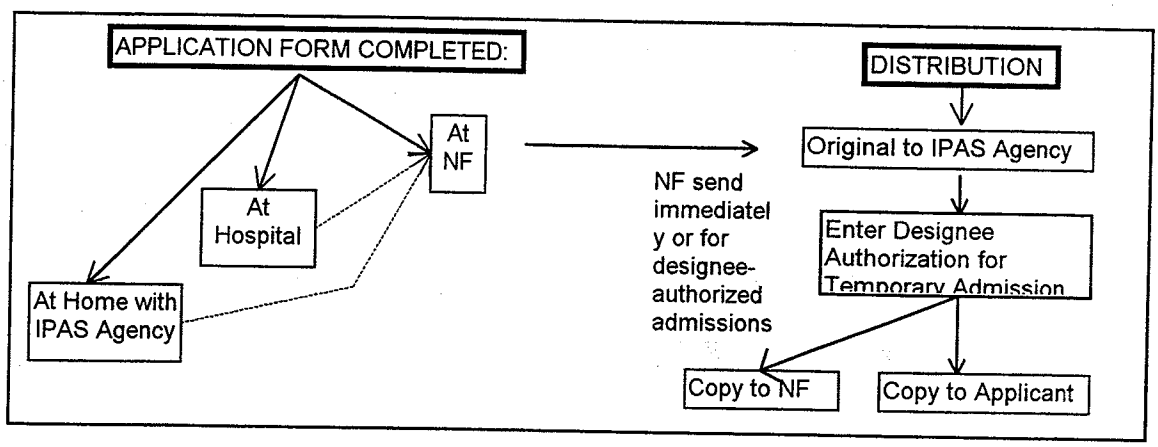
Although a hospital or IPAS agency may take the Application forms, the NF is responsible to assure that the above requirements are met.

For designee authorized admissions, the NF will assure that the IPAS application and other designated documentation are forwarded to the IPAS agency no later than:

a) immediately following the applicant's signature on the Application form; or
b) if the individual is admitted to the NF under designee authorization, within five (5) working days from the date of NF admission.

When the IPAS application is completed at the hospital or with the assistance of the IPAS agency assessor, the NF must receive it as soon as possible, but no later than at admission.

DISPOSITION OF APPLICATION FORM
Chapter 2.3.3



2.3.7 Late Applications

IPAS Applications submitted by the NF after the appropriate time limits have expired, or after an inappropriate admission, will still be processed as an IPAS assessment request. However, the NF may be reported as having committed a Class A Infraction for failure to deliver the application in a timely manner. (See Chapter 6.3.)

NOTE: Medicaid reimbursement for NF per diem can only be provided to individuals who meet Medicaid requirements as well as IPAS program requirements.

2.4 DUPLICATE/UNNECESSARY APPLICATIONS

Only one (1) Application form is valid until a PAS Form 4B is issued to close the case.

The IPAS agency must:

a. review each Application form received to determine whether it is valid and should be processed; and
b. ask sufficient questions of the referring NF, the applicant, and the family to determine:
   1) the status of the individual's immediate past placement and care history; and
   2) the completion of other Application form at another NF.

The IPAS agency should quickly review its records to ascertain whether it has an IPAS assessment currently in process. Action to process the assessment will be stopped as soon as it is found that the IPAS application was inappropriately completed.

The IPAS agency will clearly:
a) mark any additional/duplicate Application form(s), "void;"
b) make a notation of why the Application form has been voided;
c) list the date of the current Application form on the duplicate copy, initial and date;
d) retain a copy of the voided Application form in the IPAS agency's file; and
e) return the original of the voided Application form to the NF.

2.4.1 Application in Another Area

Questioning should reveal whether an Application form has been completed at a NF in another IPAS agency's area. (See Chapter 2.4.4.)

2.4.2 Transfer Between NFs

NFs are required to transfer the IPAS Application form and other pertinent IPAS documentation to any NF that admits the individual. (See Chapter 3.9.) Duplicate Application forms should not be taken because of a transfer between NFs. If a duplicate is filled out, the IPAS agency will follow procedures in Chapter 2.4.

2.4.3 Transfer Between IPAS Agencies

Coordination between IPAS agencies is required when:
a) application for IPAS is made at a NF(s) in the catchment area(s) of more than one IPAS agency; or
b) an at-home applicant lives in the area of one IPAS agency, but requires emergency admission in the area of a different IPAS agency.

2.4.3.1 Process to Transfer Case

The IPAS agency serving the area in which the applicant resides will:
a) receive and review the Application form, Level I, and applicable application forms for completeness;
b) certify the Level I for Level II need;
c) act as IPAS designee for temporary NF admission when requested; and
d) transfer the case record, after the applicant is admitted, to the IPAS agency serving the area of the NF.

2.4.3.2 Process to Receive Case

The IPAS agency serving the area of the NF will:
a) act as liaison between the first IPAS agency and the NF, as needed;
b) receive and finalize the case processing;
c) issue the PAS Form 4B to notify applicable entities of the case disposition; and
d) maintain the case record on file.

2.4.4 New Versus Readmission

During questioning it may be revealed that the individual has been in more than one NF. The IPAS agency will need to establish the individual's placement history.

Review Chapter 2.2 for a discussion of "new admission." For purposes of IPAS and PASRR, "readmission" applies to direct transfer from one NF to another NF, with or without an intervening hospital stay. The individual remains within the cycle of long-term care without a return to a community living arrangement.

NOTE: The Medicaid "bed-hold" provision does <u>not</u> affect IPAS or PASRR. The "bed hold" provision only applies to Medicaid reimbursement. Do <u>NOT</u> take a new Application form or complete a new IPAS assessment unless the long-term care cycle has been interrupted. (For reimbursement only, the Medicaid bed-hold policy considers an individual as "discharged" from a NF if the individual's hospital stay exceeds 15 days. Contact OMPP for questions concerning

Medicaid "bed hold" policy. See Chapter 2.7 for additional information on Medicaid reimbursement.)

2.4.5 IPAS Penalty

An Application form completed by an individual under IPAS penalty is not valid:

a) unless one (1) continuous year from the date of NF admission has passed; or
b) the IPAS penalty has been relieved due to "SNF" level of services need. (See Chapter 6.2.)

NOTE: An NF that admits an individual from another NF, either directly or via an intervening hospitalization, is responsible for obtaining a copy of the PAS Form 4B (or HCBS Form 3 or 7, for Waiver recipients) authorizing the initial admission. Without this documentation, a NF may be accepting an individual who is still subject to the IPAS penalty, was denied admission under the IPAS (and PASRR) regulations, or was never notified of the IPAS requirements.

2.4.6 HCB Waivers

Medicaid Waiver recipients of:

a) Aged and Disabled (A&D) Waiver; or
b) Medically Fragile Children's (MFC) Waiver

services must be assessed under IPAS to qualify for the Waiver's services. (See Chapter 7.)

Completion of PASRR Level II, however, is postponed until after the individual exercises his or her option to choose NF admission, but PRIOR to NF admission unless the recipient qualifies for PASRR APS or Exempted Hospital Discharge NF admission.

2.4.7 "Missed PAS" Level II

Missed PAS/PASRR Level II occurs when Level II should have been done as part of IPAS, but was never completed. The PASRR Level II assessment and determination must be completed as soon as the need for Level II is identified, within applicable PASRR time frames for "Missed Level II." (See Chapter 14.3.)

When the PAS Form 4B (or HCBS Form 3 or Form 7 for Waiver recipients) has already been issued because IPAS is done, the Level II is to be completed under RR of PASRR as a "Missed PAS Level II." (See Chapter 14.3.)

2.5 PASRR: IPAS AND LEVEL I

Every admission to a Medicaid certified NF must have a Level I: Identification Evaluation Criteria screen completed to determine the need for a Level II assessment.

2.5.1 Level I Form

The Level I is a screening tool which:

a) is part of the IPAS application form and accompanies the IPAS application when it is submitted to the IPAS agency;
b) consists of eight (8) questions;
c) is designed to ascertain whether the individual has or is suspected of having a condition of mental illness (MI) and/or mental retardation/developmental disability (MR/DD); and
d) is the initial determiner of need for Level II assessment.

(See Chapter 10 as well as instructions for completion of the Level I at Appendix F, Level I Decision-Making Protocol.)

2.5.1.1 Level I Completion

The entity completing the Level I must be:

a) a professional person;
b) having or be able to obtain sufficient knowledge of the applicant's condition to answer the eight (8) questions;
c) able to clarify unclear information; and

d) if applicable, able to document the reason prescribed psychotropic medications would not require Level II.

2.5.1.2 Level I Review

The IPAS agency will:

a) review the Level I and all additional collateral for completeness;
b) determine whether PASRR Level II assessment is required; and
c) certify the need for PASRR Level II assessment at the bottom of the Level I form. (Apply the Level I Decision-Making Protocol in Appendix F.)

NOTE: The Level I is not always the sole criterion for determining the need for Level II. Additional information which enhances or contradicts the responses on the Level I must be considered in the determining whether Level II is needed. When the decision to refer for Level II is contrary to responses on the Level I, the IPAS agency will make a clear notation on the Level I, documenting the reason for referral, sign or initial, and date the notation.

When it is determined that Level II assessment is needed, the applicant cannot refuse to participate in IPAS and be admitted to or remain in a Medicaid-certified NF. (See Chapter 10 for instructions on Level I.)

2.5.2 "Depression Screen"

Determination of need for Level II may be difficult when the diagnosis is "depression." The "Depression Screen" is a tool designed to assist IPAS agencies in making this decision. When "situational depression" is claimed, the Depression Screen will assess and document the duration and degree of intensity of the depression. (See Appendix V.)

NOTE: A diagnosis of Bi-polar Disorder, Major Depression, or any serious depression will always require Level II, regardless of claims that it is due to a "situation," either medical or otherwise.

If the PASRR/MI Level II will be delayed or deferred based on results of the Depression Screen, the IPAS agency will:

a) so note at the bottom of the Level I; and
b) enter the caveat from the back of the Depression Screen on the PAS Form 4A; and
c) include a copy of the Depression Screen in the case record; and
a) submit the case to the State PASRR Unit for determination.

2.6 PROCESSING APPLICATION FORM AND LEVEL I

The IPAS agency will date-stamp every document upon receipt.

2.6.1 Action by IPAS Agency

The IPAS agency will initiate the following steps as soon as it receives the Application form:

a) immediately review the application for completeness:
   1) assure that a box is checked for either "AGREE" or "DO NOT AGREE;
      (Applications checked "DO NOT AGREE" will not be assessed or, if the complete assessment is done in error, will not be fully billed by the IPAS agency.)
   2) review that the Application form is appropriately signed and dated; (
      (If signed by someone other than the applicant, check that the relationship is specified.)
b) assure that the appropriate written IPAS designee authorization for temporary admission is executed:
   1) as appropriate, an IPAS designee authorization will be entered:
      a. on the Application form; or
      b. for the "Exempted Hospital Discharge" exclusion, on the PASARR Level I by the physician; or

c. on an attached, completed PASARR Categorical Determination form for PASRR respite or APS; and

2) a copy of the properly executed designee authorization will be provided to the NF for its chart and the original retained in the IPAS case record to be submitted to the State;

c) review the PASARR Level I form to determine need for Level II assessment;
[The IPAS agency will certify either "Yes" or "No" on the bottom of the Level I to specify whether Level II is needed. (See Appendix F.)]

NOTE: If Level II is needed, the individual cannot "REFUSE" to participate in IPAS and be admitted to or remain in a Medicaid-certified NF.

d) calculate applicable time frames for completion of each part of the IPAS process, including the following factors among others:
1) the nature of the assessment (IPAS-only or PAS/PASARR);
2) type of IPAS case (Medicaid or non-Medicaid, at-home, in a hospital, temporary admission to a NF);
3) nonresident.]

e) schedule and arrange for the IPAS assessment;
(This includes contacting as appropriate the applicant, his or her family or legal representative, and other persons who are knowledgeable about the applicant's condition and situation, assigning the case to an IPAS assessor, and beginning tracking of case processing.)

f) contact the designated attending physician to obtain the necessary medical documentation and related service needs information.

Upon request, the IPAS agency will provide the physician with a thorough explanation of:
a) IPAS including the appointment (under IC 12-10-12-14) of the attending physician as a team member;
b) IPAS goals and objectives;
c) the need for medical and mental health information; and
d) the need for expeditious completion of the necessary forms.

To expedite submission of necessary medical documentation, the IPAS agency may:
a) solicit assistance from a family member or the legal representative to contact the physician in this regard; and
b) encourage the hospital discharge planner to assist in getting the physician's signature on the Form 450B, Physician Certification for Long-Term Care Services.
Delay in receipt of medical documentation, including IPAS follow-up dates and results, will be documented by the IPAS agency in the IPAS case record.

NOTE: Delay in receipt of necessary medical documentation is the most common cause of case processing delay.

2.6.2 Referral for Level II

If referral for PASRR Level II assessment is needed, the IPAS agency will:
a) notify the applicant in writing that the Level II referral is being made as soon as the need for Level II assessment is identified; and
b) make referral for PASRR Level II for individuals with:
1) MI (mental illness) are made to the local CMHC (Community Mental Health Center) serving the NF identified by the applicant or his or her representative; or
2) MR/DD (mental retardation/developmental disability) or MR/DD/MI are made to the local D&E Team.

The IPAS agency may use the form letter in the Appendices to send notice of referral for Level II to the applicant. It may be copied on the IPAS agency's letterhead. (See Appendix X.) Follow PASRR procedures in Chapters 10-16.

NOTE: If Level II is NOT needed, a notice does not need to be sent.

2.6.3 "Refuse/Do Not Agree"

Medicaid regulations do not allow an individual who needs a PASRR Level II assessment to refuse IPAS and be admitted to or remain in a Medicaid certified NF.

When the individual is non-PASRR, he or she may "refuse to participate in IPAS" and the NF may admit the individual under IPAS penalty. The NF will:

a) provide a copy of the IPAS Information Sheet and allow sufficient time for the person signing the Application form to read it; and
b) assure that the applicant understands the possible consequences of refusing to agree to participate in IPAS; and
c) make a clear notation on the application form itself, including the stated reason for refusal (and other applicable information); and
d) sign and date the notation on the IPAS Application PRIOR to sending it to the IPAS agency; and
e) keep a copy of the IPAS Application on file for at least one (1) year if the individual who refuses to participate is admitted to the NF; and
f) send the original IPAS Application to the IPAS agency immediately [or no later than within five (5) working days for designee authorized temporary admissions].

The IPAS agency will issue a PAS Form 4B which states the penalty for nonparticipation in IPAS, including the dates under IPAS penalty. (For more detail, see the IPAS Penalty in Chapter 6.2.)

NOTE: A Medicaid recipient may refuse to participate in IPAS, be admitted, and incur the IPAS penalty. Medicaid reimbursement will not be available for NF per diem, however.

2.6.4 Case Termination PRIOR to IPAS Completion.

An IPAS agency will:

a) not pend an IPAS or PASRR case beyond applicable IPAS and/or PASRR processing time frames; or
b) if it is necessary to pend the case, clearly document the reason.

For example, do not pend a case because the individual has changed their decision or cannot make a decision on whether NF placement is still wanted. Terminate the case due to voluntary withdrawal, refusal to participate, or failure to cooperate, as applicable. (Also see Chapter 5.2)

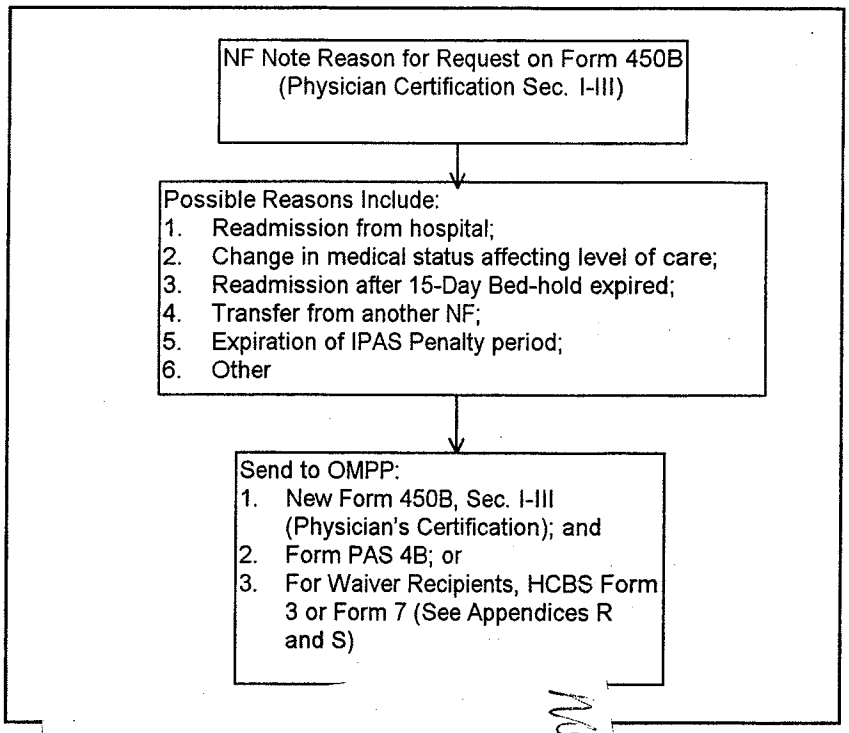
2.7 MEDICAID REIMBURSEMENT WHEN IPAS NOT REQUIRED

When an individual becomes Medicaid eligible and needs Medicaid reimbursement after a PAS 4B has been issued, the NF will:

a) obtain documentation to support the patient's current need for NF level of services (level-of-care) on Form 450B; and
b) make a copy of the PAS 4B (or, for Medicaid Waiver recipients, HCBS Form 3 or 7 in lieu of the PAS Form 4B); and
c) state the reason for submission of the documentation at the top of the Form 450B; and
d) submit the documentation and request directly to OMPP.

If a period of IPAS penalty has expired, the NF should include:

a) the original date of NF admission; and
b) a certification that the one (1) year penalty period has expired.



To obtain a PAS 4B w or file, the NF must:

a) contact the local IF
b) contact the prior N F, with or without an intervening hospital stay; or
c) as a last resort, pro orm 450B explaining why a PAS 4B is not being incl

The cover letter should i tion:

a) if available, a copy o
b) the date that the indi
c) assurances to OMPP care since the original date of NF admission (no disc me); and
d) a statement from the e to locate a copy of the PAS Form 4B.

Medicaid Reimbursement 2 of 4 B 1

2.8 IPAS AND MEDI

Medicaid recipients seeking d Managed Care Organization (MCO). NF admission for Me ASRR requirements. Medicaid reimbursement for the NF sta

2.8.1 General Inform

For IPAS and PASRR p ...CO enrollee NF admissions are divided into two (2) categories:

a) "short-term NF placement;" and
b) "long-term NF placement."

Intended length of stay is the criterion to be used for these placements. Time frames for short-term placement are established according to current corresponding IPAS and PASRR criteria (See Chapter 3), except for Direct from Hospital placements (See Chapter 2.8.3.3.).

2.8.2 Identification of MCO Enrollees

It is important for the IPAS agency to identify the MCO enrollee status of NF applicants as soon as possible. Information on MCO status should be recorded:

a) on the Application for Long-Term Care Services for in the section for recording "Medicaid Status;"
b) in information provided by the NF;
c) through hospital discharge planner completion of Section II, Temporary Authorization, on the Application form;
d) by a statement of the applicant or health care representative; and/or
e) through other sources.

2.8.3 IPAS Agency Action

The IPAS agency has the following responsibilities:

a) inquire about MCO enrollee status for every applicant who is a Medicaid recipient
b) when it is indicated that the applicant is an MCO enrollee, confirm status by calling the MCO Helpline at 800/889-9949;
c) review the Application form for appropriate completion;
d) review the Level I and decide need for PASRR Level II;
e) assure that the Application form, PAS Form 4A, PAS Form 4B (when issued by IPAS agency for temporary admissions or case termination), and any other documents deemed applicable by the IPAS agency show MCO status in the Medicaid status sections;
f) issue IPAS agency designee IPAS and PASRR authorizations for temporary admission, including notation of MCO enrollee status; and
g) immediately forward a copy of completed PAS Form 4B to the applicable Medicaid MCO provider, including PAS Forms 4B giving authorization for temporary admission as well as final determinations.

Notations of MCO enrollee status must be readily identifiable by the NF, OMPP, State PASRR Unit, BDDS Offices, and other IPAS agencies.

2.8.4 Processing MCO Enrollee Cases

NF identification of MCO Enrollee status is a reimbursement issue. It is the responsibility of either the NF or the hospital to notify the MCO of NF placement as soon as possible. The role of the IPAS agency is to assist with early notification to the MCO whenever an IPAS applicant is found to be an MCO enrollee.

2.8.3.1 "Short-Term NF Placement"

Following current IPAS procedures, short-term NF placement:

a) may be designee authorized using the applicable IPAS Direct from Hospital, Emergency/APS, 30-Day Short-Term, or PASRR Exempted Hospital Discharge, Respite or APS authorizations;
b) will use the current time frame restrictions for such admissions.

If circumstances change during the short-term NF placement in that the individual now needs long-term placement, current procedures are to be followed. The Medicaid MCO must be notified of any change.

The Medicaid MCO assumes financial responsibility for "short-term" NF placements. NFs must bill the applicable MCO directly and not submit a claim to Medicaid fee-for-service.

2.8.3.2 "Long-Term NF Placement"

When a Medicaid MCO enrollee is admitted to a NF for "long-term" NF placement, the Medicaid MCO must disenroll the recipient. Until disenrollment occurs, the Medicaid MCO is financially responsible for NF per diem reimbursement. After disenrollment is accomplished, the NF will submit its claims to Medicaid fee-for-service.

2.8.3.3 Direct from Hospital Admissions

Working with the Medicaid MCO, it is the responsibility of the hospital discharge planner to determine whether placement of an MCO enrolee is intended to be for a "short" or "long term." The hospital discharge planner will follow current IPAS/PASRR procedures, including the following:

a) complete Section II on the Application for Long-Term Care Services form as applicable:

1) check the box for "Direct from Hospital" for non-PASRR applicants;
2) for PASRR Level II applicants, determine whether "Exempted Hospital Discharge" applies or whether the full IPAS/PASRR assessment needs to be completed prior to NF admission;
3) check the box for "Medicaid MCO Enrollee;"
4) check the appropriate box for short-term or long-term;
5) check other boxes as applicable;
6) enter the dates of authorized placement, using the date of NF admission as a start date; and
7) send the Application form and Level I to the IPAS agency with a copy to the admitting NF; and

b) follow other procedures as stipulated by Medicaid for the Medicaid MCO process.

NOTE: For Medicaid MCO IPAS "Direct from Hospital" authorized stays, "short-term" is defined to be a stay of less than 120 days in the NF. This differs from the usual limit of twenty-five (25) days for a Medicaid recipient, applicant, or will apply.

For IPAS "Direct from Hospital" Medicaid MCO enrollees, the IPAS agency will:
a) follow IPAS procedures for private-pay applicants; and
b) follow-up after ninety-five (95) days to determine whether the individual is still in the NF and whether discharge is planned prior to the expiration of 120 days.

If the individual has been admitted for a short-term stay, the IPAS agency will:
a) issue a PAS Form 4B to close the case at the expiration of the authorized time; and
b) send a copy of the PAS 4B to the Medicaid MCO.

If the individual needs to remain longer than the 120 days, it is the responsibility of the NF to:
a) notify the IPAS agency in writing of the reason the stay will last beyond 120 days; and
b) specify the length of time that will now be needed.

The IPAS agency will schedule completion of the IPAS assessment and determination within twenty-five (25) days, assuring that the Medicaid MCO receives a copy of the PAS Form 4B.

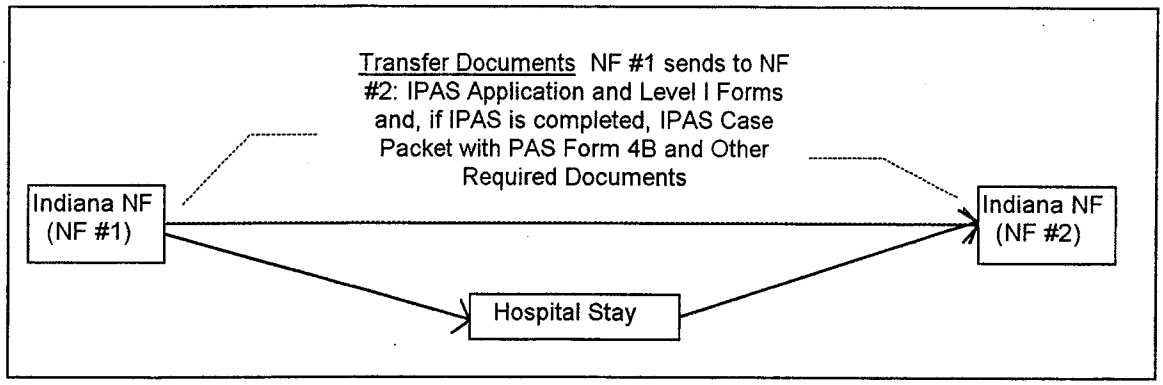
2.9 NF TRANSFER AND READMISSION

After IPAS has been completed and a form PAS 4B issued, the resident may transfer between NFs, with or without an intervening hospitals stay, without another IPAS assessment. Do NOT take a new IPAS Application form for an individual who is transferring in from one Indiana NF to another Indiana NF.

The transferring NF (NF #1) must:
a) transfer all IPAS and/or PASRR documentation with an individual to the new (admitting) NF; and
b) provide the original IPAS Application and Level I forms with, or prior to, transfer of the individual.

Medicaid and the ISDOH have always required transfer of pertinent medical documents and patient information between NFs. The transferring NF should retain a copy of the IPAS application and any other documents it deems necessary for at least one (1) year from the date of admission.

When patient transfer occurs before the IPAS process has been completed (PAS Form 4B has not been issued):
a) the new NF (NF #2) must immediately contact its IPAS agency to alert the IPAS agency to the transfer;
b) give to the IPAS agency the name, address, and phone number of the NF from which the patient is transferring; and
c) if NF #2 is in the area of a different IPAS agency, the IPAS agencies will work out an agreement for finishing the case processing; and
d) notify NF #2 of the results.



NOTE: When PASRR Level II is involved, refer to Chapter 14.

2.10 HOSPITAL-BASED NF UNITS

IPAS admission requirements for a hospital-based NF unit depend on the licensure, not survey, status of the hospital-based unit. See Chapter 3.8 for information on admission and discharge from hospital-based NF units.

IPAS & PASRR MANUAL

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- 3.8.4 "Hospital-Llicensed" (IC 16-21) Hospital-Based NF Unit
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Chart: Hospital-Based NF Units (Chapter 3.6)

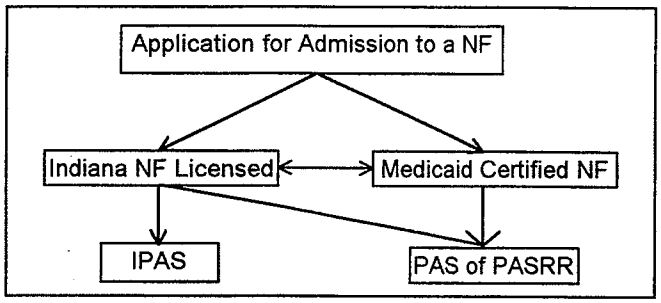
Chapter 3

ADMISSION REQUIREMENTS

All licensed Indiana NFs (under IC 16-28-2) must follow the admission requirements of IPAS (and, when Medicaid-certified, PASRR).

This Chapter will define the circumstances and parameters for admission into Indiana's licensed nursing facilities (NFs).

NF REQUIREMENT FOR IPAS/PASRR
Chapter 3



3.1 NF ADMISSION

See Chapter 2 for information on required forms for NF admission. This Section will provide information on IPAS admissions. For PASRR, refer to Section 200.

3.1.1 General Criteria

NF admission may be intended for:
a) short-term stay; or
b) long-term placement.
For IPAS purposes, "long-term" is generally defined to be a stay of 120 days or longer.

NF admission may occur:
a) after an IPAS and/or PASRR assessment and determination has been completed; or
b) with authorization for a temporary stay during which the IPAS and/or PASRR assessment and determination are in process; or
c) with authorization for a temporary period of time with discharge following the stay. Assessment and determination are not done.

IPAS (and, when required, PASRR) assessment and determination must be:
a) completed **PRIOR** to NF admission; or
b) within an authorized temporary time period and either:
   1) completed following NF admission (Direct from Hospital, Emergency/APS, or PASRR APS); or
   2) deferred until a later date (30-Day Short-Term, Respite, Five-Day Transfer Within CCRC, or PASRR Respite); or
c) not completed (Respite Stay, .30-Day Short-Term, PASRR Exempted Hospital Discharge, death, discharge home from the NF, etc.).

3.1.2 Time Frames

Most activities pertaining to IPAS and/or PASRR are governed by specific time frames. Use this chapter to refer to the type of NF admission contemplated to ascertain applicable time frames for case processing and temporary stays.

a) Establish need for Level II PRIOR to authorizing temporary admission:
Temporary admission authorizations and case processing time frames differ between IPAS and PASRR. Need for PASRR Level II assessment must be established before temporary authorization is given.

b) Time frame adjustment when case switches from private-pay to Medicaid:
When an individual who was admitted as private-pay indicates that Medicaid will be needed, the NF must immediately notify the IPAS agency. The IPAS agency will:
1) redesignate the case as a Medicaid case; and
2) adjust its time frame, as appropriate, to the Medicaid 25 day limit.

3.2 FROM HOME (OR OTHER NON-INSTITUTIONAL LIVING ARRANGEMENT)

Whenever possible, the IPAS assessment will be conducted in the applicant's home or other non-institutional living arrangement.

a) The most effective assessment of the individual's current living environment and needs can be made in the home setting. When assessment is completed during temporary NF admission, the assessor should strive to identify functional limitations that would be present in a home or community living setting.

b) Alternative community services to support continuing independence and delay long-term NF placement also need to be based on availability within the locality of the home or community.

3.2.1 Time Frame

The IPAS assessment and final determination will be made:

a) as soon as possible, but no later than twenty-five (25) days from the date of signature on the Application form; and

b) when more time is required, the IPAS agency must clearly document the reason(s) and applicable dates the case is pended in the case record.

When "Emergency Admission" is required in the course of the At-Home assessment, an additional 25-days may be added to the expired time, not to exceed a total of 50 days. (See Chapters 3.2.4 and 3.4.)

3.2.2 Completion of IPAS Forms

The Application and Level I forms may be completed at the NF, or the IPAS agency representative may assist with completion of the IPAS Application form and Level I at the time of the home visit.

To expedite completion of the Form 450B, Physician Certification of Need for Long-Term Care Services, the IPAS assessor may give it to the applicant or a family member to deliver to the attending physician for completion. At times the physician is more responsive to a request from the family member. It is also helpful for the IPAS agency representative to give a preaddressed envelope to the applicant for the physician to mail the completed Form 450B directly to the IPAS agency.

3.2.3 NF Waiting Lists

When an individual intends to enter a NF, but his or her name is placed on a waiting list, the IPAS Application and assessment process will be completed within applicable time limits while the individual is awaiting placement. This allows the full assessment and final determination to be rendered during the waiting period. When the NF bed becomes available, expeditious placement can be made.

NOTE: The PAS Form 4B is only valid for 90 days from the date of issuance if the individual has not been admitted to a NF. NF admission terminates use of the 90-day period. (See Chapter 5.1.)

3.2.4 Emergency Admission During "From Home" Assessment

If an individual's condition and/or situation deteriorates to the point that an emergency occurs during the course of the "From Home" assessment, the IPAS agency may authorize "Emergency

Admission" if the Emergency criteria are met. (See "Emergency Admission," Chapter 3.4.) The details of the emergency must be clearly explained in the case record.

3.3 TEMPORARY NF ADMISSIONS

An individual may be temporarily admitted to a NF either:

a) while the full IPAS assessment is in process, e.g., for an emergency; or
b) for a short stay when he or she meets criteria to be exempted from completion of full IPAS, e.g., for respite care.

Temporary stays must always have the IPAS designee's authorization PRIOR to NF admission (except for certain "Emergency/APS" admissions (see Chapter 3.4), and the "Five-Day Short-Term Within a CCRC" exemption (see Chapter 3.6). "Direct from Hospital" admission requires prior authorization from either the IPAS agency designee or the appointed hospital discharge planner designee (see Chapter 3.7),

3.3.1 Time Frame

Medicaid recipients, applicants, Medicaid pending and will-apply for Medicaid applications will always be completed as soon as possible, but no later than twenty-five (25) days from the date of application or that Medicaid status is identified.

When an individual who was admitted as private-pay indicates that Medicaid will be needed, the NF must immediately notify the IPAS agency. The IPAS agency will:

a) redesignate the case as a Medicaid case; and
b) adjust its time frame, as appropriate, to the Medicaid 25 day limit.

3.3.2 IPAS Designee

An IPAS designee is an individual appointed by the IPAS agency, with approval of BAIHS, who may authorize temporary admission to a NF. IPAS designees are individuals:

a) employed by the IPAS agency; or
b) employed as an Indiana hospital discharge planner and appointed by the IPAS agency.

NOTE: Hospital discharge planners are only allowed to authorize "Direct From Hospital" NF admissions for transfers from acute-care level beds only. (See Chapter 3.7.)

An individual acting as IPAS designee must:

a) assure that the Level I form has been completed;
b) assure that the IPAS Application form has been completed (See Chapter 3.7.3.2 for hospital instructions.);
c) make a preliminary judgment of the need for PASRR Level II assessment;
d) (IPAS agency only) complete certification of need for Level II at bottom of Level I;
e) determine whether requirements for temporary NF admission are met;
f) for long-term placement requests, gather sufficient information to make a decision of need for NF level of services, i.e., whether the applicant qualifies for at least temporary admittance to a NF because services necessary to care for the individual in the community are not available except in a NF setting (substantially complete assessment - see Chapter 3.3.3);
g) record the IPAS designee's authorization on the appropriate form (IPAS Application form or PASRR Categorical Determination form); and
h) for hospitalized applicants, check that a copy of the designee-authorized record from the hospital is transmitted to the NF in a timely manner, but no later than the date of admission.

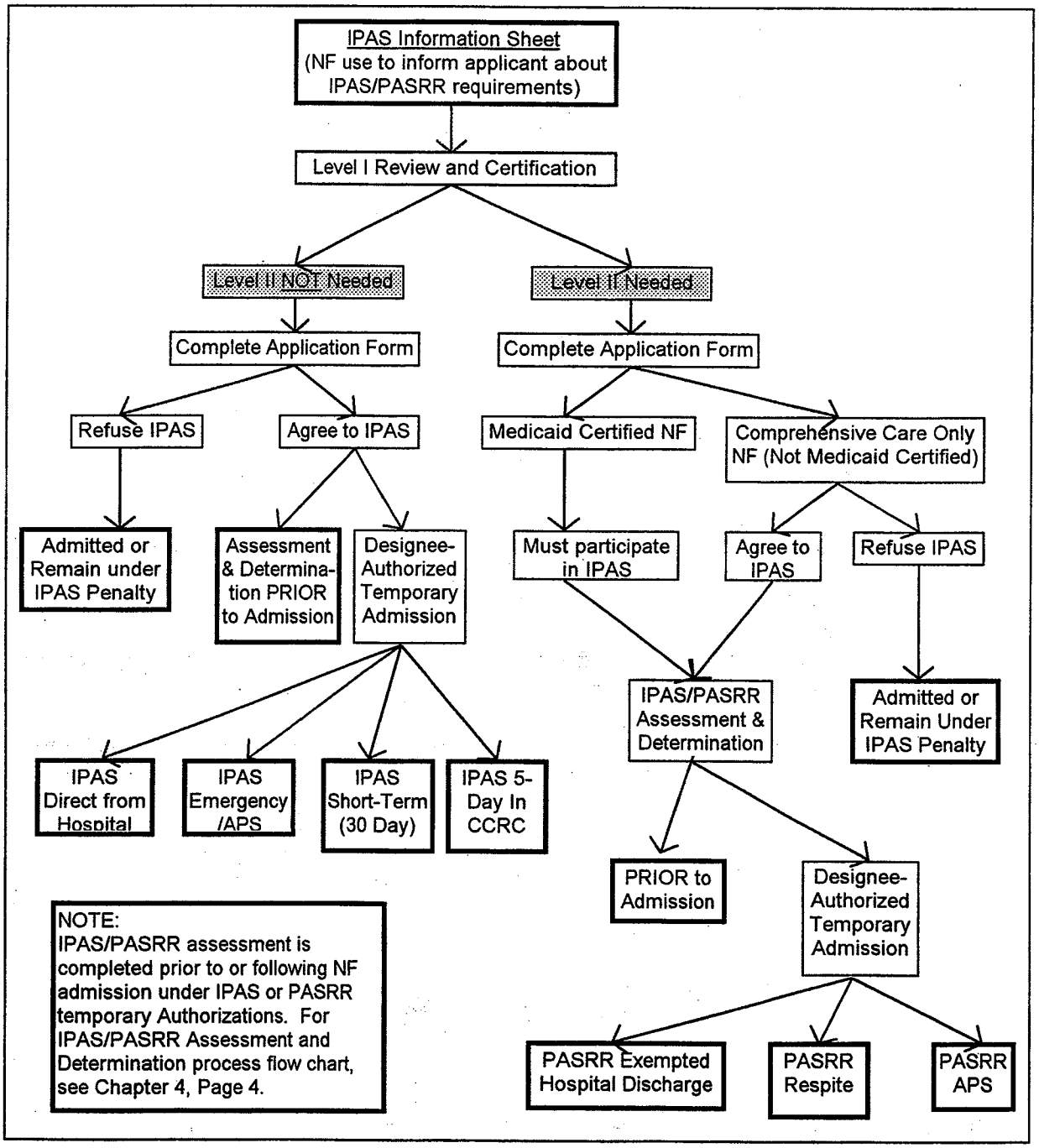
3.3.3 "Substantially Complete Assessment"

For long-term placements from an acute care hospital bed, an IPAS designee must conduct a "substantially complete IPAS assessment" (See Chapter 4.3.1.) to determine whether criteria for temporary NF services are met pending the completion of the entire IPAS assessment.

The entity requesting designee-authorization for temporary NF admission must provide sufficient information for the designee to determine whether the type of admission being requested meets requirements. A review of documentation and information will culminate in a judgment of whether requirements are met and temporary NF placement may be authorized.

The designee authorization for temporary NF placement is invalid if there is not sufficient information for a decision, or the information does not support the need for the temporary admission.

NF TEMPORARY ADMISSION PROCESS
Chapter 3.3



3.3.4 Transmittal of Authorization

The IPAS designee must:

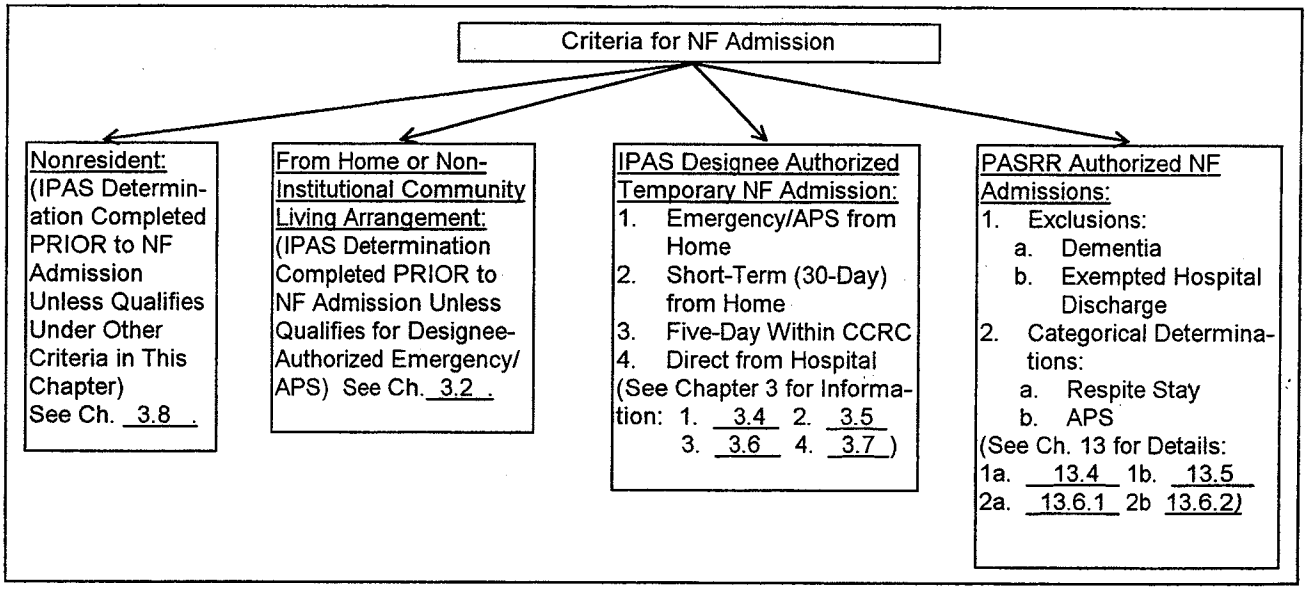
a) record in writing all decisions regarding the allowance or disallowance of temporary placement on the:
   1) IPAS Application form (for IPAS Only); or
   2) PASRR Level I form (for PASRR Exempted Hospital Discharge); or
   3) PASRR Categorical Determination form (for PASRR Respite or APS); and
b) provide notice of the decision to the applicant or his or her legal representative, the relevant NF, and the IPAS agency.

Designee authorizations by the IPAS agency may be transmitted by telephone in order to expedite NF placement. Written authorization must immediately be sent to the applicant and the NF for inclusion on the NF active record or chart.

The hospital discharge planner acting as designee must immediately transmit the necessary documentation to the NF. The NF is responsible to assure that it is forwarded to the IPAS agency, either by the NF itself or via the hospital. (Failure by the hospital to provide the NF with the necessary documentation of designee-authorization in a timely manner could result in the termination of designee status.)

The following chart shows the categories of temporary designee-authorized NF admission with applicable Chapters for quick reference. (PASRR details are addressed in Chapters 10-16.)

REFERENCE CHART FOR NF ADMISSION CATEGORIES
Chapter 3.3



3.4 EMERGENCY/APS

Emergency admission, including Adult Protective Services (APS) situations, can only be granted:

a) for individuals residing at home or in a non-institutional living arrangement; or
b) from an emergency room of an Indiana hospital.

[Admissions from the emergency room or hospital 23-hour bed-hold (non-inpatient status) of an Indiana hospital licensed under IC 16-21 are covered in Chapter 3.7.6.]

Emergency/APS authorization does NOT apply:

a) to small group home settings as they are considered to be institutional living arrangements (Small group homes are licensed as intermediate care training facilities and are Medicaid reimbursed as institutions.);
b) if PASRR Level II assessment is needed (The only "emergency" admission provision under PASRR is qualification under "PASRR APS Categorical Determination." See Chapter 207 322.):
c) to nonresidents (Only Indiana residents who are bona fide Indiana APS program participants qualify for the "APS" provision under Emergency/APS authorization.

3.4.1 Time Frame

The assessment and final determination must be completed as soon as possible but no later than twenty-five (25) days from the date of NF admission.

3.4.2 "Emergency" Defined

For purposes of IPAS, authorization for emergency admission:

a) "may be granted by the designee;
b) when a medical emergency exists in that care in the health facility is required within seventy-two (72) hours of the request for such admission; and
c) the attending physician certifies the need for such emergency admission" to the prescreening agency following IPAS procedures.

The physician's certification of need for emergency NF admission must be:

a) based on the criteria listed above;
b) in writing; and
c) included in the applicant's case record.

The IPAS agency must provide the IPAS definition of emergency to the physician.

3.4.3 Authorizing Entity

Only the IPAS agency designee may authorize Emergency/APS Admissions. The designee will:

a) determine and clearly record the nature of the emergency in the case record, obtaining as much information as possible relative to areas usually covered by the IPAS assessment (See Chapter 3.3.5.);
b) include a written certification by the attending physician; and
c) determine whether "Emergency/APS Admission" will be authorized.

3.4.4 Role of APS

When an individual is a bona fide APS recipient, the APS investigator may:

a) provide sufficient information so that the IPAS agency can determine whether emergency authorization will be granted; and
b) certify the emergency status and need for NF admission to the IPAS.

NOTE: The IPAS agency always has the responsibility to determine and document whether a bona fide emergency exists as defined in Chapter 3.4.2. The physician's and APS investigator's certifications constitute supporting documentation. They are not the sole criterion for determining approval of "Emergency/APS Admission."

3.4.5 Hospital ER or Hospital Bed-Hold

Only the IPAS agency designee may authorize admission from the emergency room (ER) or 23-hour bed-hold unit of an Indiana hospital. Authorization may or may not include APS-involvement.

The IPAS agency may appoint an APS investigator to:

a) act as an alternate designee when an after-hours IPAS agency on-call designee is not available;
b) gather information described in Chapter 3.4.6; and
c) certify on a format approved by the IPAS agency that the individual is the subject of a bona fide APS emergency.

APS authorization is only applicable until the IPAS agency is notified and approves the temporary NF admission. Both the NF and the APS designee are responsible for contacting and notifying the IPAS agency of the admission as soon as possible, but no later than the first working day following admission.

3.4.6 Supporting Information

When the NF contacts the IPAS agency (or APS) to request authorization for "Emergency/APS Admission" on behalf of an applicant, the NF will be prepared to provide as much of the following information as possible:

a) identifying demographic information for the applicant, including name, address, current location, etc.
b) the nature of the change in the individual's condition and/or situation which now causes them to seek emergency NF placement;
c) current APS involvement/intervention;
d) primary and secondary diagnoses (including physical/medical and mental diagnoses.);
e) prescribed medications including dosages, frequency, and reason(s) prescribed;
f) impairments in ADLs;
g) family and/or community services the individual is currently receiving;
h) name of a family member or legal representative who is knowledgeable about the situation and needs of the individual who can be contacted for additional information;
i) answers to the PASRR Level I screen;
j) history of recent hospitalizations or other inpatient care, including treatment and reason for treatment; and
k) any other information the PAS agency designee deems necessary in order to make a decision.

This information will be entered on a form developed by the IPAS agency as a "Documentation of Need for Emergency Admission" to be included in the IPAS case record.

3.5 SHORT-TERM (30-DAY)

An individual may be admitted from home without the required IPAS assessment:

a) for a short-term stay not to exceed thirty (30) days;
b) with an <u>expressed intent</u> by the applicant or his or her representative to leave the NF within the authorized time.

The IPAS agency designee must determine that it is probable that the individual will be discharged from the NF within thirty (30) days from the date of admission. The IPAS agency must collect sufficient information to be able to make this decision.

NOTE: Do <u>NOT</u> use Short-Term (30-Day) authorization for direct from hospital admissions. Persons in a hospital acute care bed can only use:

a) "IPAS Direct From Hospital" authorization;
b) "PASRR Exempted Hospital Discharge;"
c) full IPAS/PASRR assessment; or
d) IPAS (non-PASRR) refusal to participate in IPAS.

3.5.1 Time Frame

Short-Term (30-Day) admission are limited to a stay not to exceed thirty (30) days from the date of NF admission.

If approved, the IPAS agency designee will:

a) enter the approval on the original IPAS Application with the authorized time limit specified;
b) forward a copy to the NF; and
c) after the expiration of the authorized time limit, issue a PAS 4B specifying the type of approval and time limits.

No further action is required by the IPAS agency unless there is a change in the applicant's condition or situation.

3.5.1.1 Extension Beyond 30-Days

If the applicant's condition or situation changes such that NF placement is needed beyond the 30-day approved time, the applicant or NF (acting on the individual's behalf) must, PRIOR to the expiration of the approved time:

a) notify the IPAS agency;
b) in writing;
c) requesting an extension of the authorized time; and
d) include an explanation of the change which now necessitates additional care in the NF specifying:
   1) whether additional short-term care or long-term care is now needed; and
   2) if short-term, the anticipated number of days needed.

3.5.1.2 Extension Authorization

"Short-Term (30-Day)" authorization may be extended for no more than twenty-five (25) days additional days (maximum 55 days).

The IPAS agency will:

a) decide whether extended placement should be authorized;
b) record the decision on the original IPAS Application form;
c) initial and date the notation; and
d) provide a copy to the applicant and the NF.

A copy of the NF request letter and the updated IPAS Application form must be included in the IPAS case record.

If extended stay is approved, the IPAS agency will:

a) conduct the complete IPAS assessment;
b) process the case for final determination' and
c) if it is a non-Medicaid case, issue the PAS 4B specifying that the original admission was for Short-Term 30-Day, extended to a given date.

The IPAS assessment may result in a decision/recommendation on the PAS Form 4A or 4B to:

a) approve NF placement for an:
   1) extended but time-limited placement; or
   2) for long-term placement; or
b) deny continued NF placement.

3.5.2 Definitions

The IPAS agency should be aware of the following considerations.

a) "Short recuperative care" is a temporary service by which care is provided to assist an individual to regain the minimum level of independent functioning. Such care may be needed due to malnutrition, need for temporary diabetic diet monitoring or insulin adjustment, medication adjustment or monitoring, or other short-term medical need. The need for care will be documented in the IPAS case record.

b) "Respite care" is a temporary or periodic service by which care is provided to a functionally impaired individual for the purpose of relieving the regular, unpaid caregiver. Non-Medicaid individuals may utilize the short-term 30-day stay for respite purposes.

   For Medicaid purposes, the term "respite" should only be applied to Medicaid applicants admitted under PASRR's Categorical Determination for Respite Care (See Chapter 13.6.1.) or Medicaid A&D or MFC Waiver Respite Care (See Chapter 7.). To avoid confusion, the IPAS agency should always refer to eligibility under this criteria as a "Short-Term or (30-Day)" admission and avoid use of the term, "respite."

However, if medical need for NF level of services is present and shown in the record, Medicaid eligible individuals may use the Short-Term (30-Day) for a short stay. It is Medicaid's decision whether Medicaid will reimburse for the NF stay. Under these circumstances, the IPAS agency should clearly document this purpose on the IPAS Application form or an attachment.

c) The "Short-Term (30-Day)" provision may also be used for transfers within a CCRC when the individual is anticipated to need a stay which will be more than 5-days in length. No more than 30-days may be approved for the Short-Term 30-Day stay. (See Chapter 3.6.)

3.6 FIVE-DAY TRANSFER WITHIN A CCRC

A non-PASRR individual may be transferred into a NF bed for a short-term stay (five days or less) within a Continuing Care Retirement Center (CCRC) without applying for IPAS or receiving designee-approval.

NOTE: The individual must be a current resident of the same CCRC in which the transfer is occurring. The "Five-Day Transfer Within a CCRC" cannot be used for admission of an individual from an outside living arrangement.

Prior to using this provision, a Medicaid-certified NF must complete a new Level I form to determine and document current PASRR status. If Level II is required, the PASRR admission requirements must be followed and the Five-Day Transfer provision cannot be used. (See Chapters 10-16 of this Manual.)

3.6.1 Time Frame

A short recuperative or respite stay not to exceed five (5) days is exempted from the IPAS requirement for the five (5) day period only.

3.6.2 Extended Stay Request

The "Five-Day Transfer Within a CCRC" stay may be extended when the individual:

a) does not recuperate within the anticipated period (five days or less); or
b) the NF stay needs to be extended due to a change in circumstances.

The individual (or NF if designated by the individual) must immediately notify the IPAS agency:

a) explaining the need for extended stay;
b) giving the anticipated length of stay needed; and
c) obtain IPAS agency designee authorization.

Notification may be made by telephone, followed by a written notification.

NOTE: The Application form and Level I must be completed no later than the fifth (5^{th}) day following admission. These forms must be sent to the IPAS agency within five (5) working days.

3.6.3 IPAS Agency Designee Authorization

The IPAS agency designee may authorize up to an additional twenty-five (25) days, not to exceed thirty (30) days using the Short-Term 30-Day provision.

3.6.3.1 Extended Short-Term Stay

When it is anticipated that the applicant will need an additional stay of 30 days or less, the IPAS agency will:

a) follow procedures for "Short-Term (30-Day) Admissions" (See Chapter 3.5);
b) certify authorization for temporary stay on the original IPAS Application form submitted by the NF; and
c) forwarded a copy to the NF to:
   1) give to the applicant; and
   2) maintain on the individual's active record/chart.

The case record will record the use of the "Five-Day Short-Term Transfer Within a CCRC" exclusion including the individual/NF's written explanation of need for longer stay.

3.6.3.2 Long-Term Stay

The NF must notify the IPAS agency when the applicant's condition indicates need for long-term NF placement. The IPAS agency will:

a) extend the authorization for placement using the "Short-Term 30-Day" provision as above; and
b) will immediately begin full IPAS assessment following regular IPAS procedures.

3.7 DIRECT FROM HOSPITAL

To expedite timely hospital transfer of individuals who need the level of care provided in a NF, a hospital discharge planner may be appointed to authorize temporary placement into a NF under specific conditions.

NOTE: For transfers from a hospital emergency room (ER), hospital 23-hour holding unit, or "after hours" discharges, see Chapter 3.5.4, Emergency/APS Admissions.

3.7.1 Basis of "Direct from Hospital"

The "Direct from Hospital" authorization is allowed based on a presumption that:

a) an individual receiving acute level of care in a hospital will have at least minimal NF level of services need;
b) for at least a short period of time, during which the full IPAS assessment is completed.

A "substantially complete assessment" is required to establish temporary need for NF level of services. (See Chapters 3.3.3 and 4.3.1.)

3.7.2 Appointment of "Hospital Discharge Planner" Designee

The IPAS agency may:

a) execute a written agreement between the hospital and the IPAS agency, subject to approval by BAIHS, for the hospital discharge planner designee activity; (See Appendix D1.) and
b) appoint the hospital discharge planner(s) to act as an IPAS designee for discharge from an acute-care hospital bed only.

NOTE: "Direct From Hospital" authorization does not apply to transfers between hospital NF units, subacute or non-acute care placements.

Discharge planners must:

a) complete an IPAS training on the duties and function of an IPAS designee; and
b) be certified by the IPAS agency PRIOR to acting as an IPAS designee.

Failure to follow requirements could result in revocation of an individual's appointment as IPAS designee or in loss of the hospital's designee activity status.

NOTE: In certain circumstances, the authorized IPAS agency representative will act as designee for requests for NF admission from the hospital's ER or 23-hour bed hold (Chapter 3.4.4) and hospital-based nursing (NF) units (Chapter 3.7.8).

3.7.3 Procedures for "Direct from Hospital"

Hospital discharge planning is the act of identifying patient needs and preparing for an effective, efficient and timely discharge of the patient. It includes linking patients with appropriate services (facility-based and/or community-based) when they are discharged.

> "The hospital must identify at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning will begin on the day of admission to the hospital." (42 CFR 483.43) (See Appendix J.)

IPAS is to be coordinated with this process.

3.7.3.1 Completion of "Level I"

Level I should always be completed prior to completion of the IPAS Application form to identify whether "Direct from Hospital" authorization can be used. Follow the steps diagrammed in Chapter 3.1.

3.7.3.2 Completion of IPAS Application Form

The IPAS Application form may be completed:

a) at the admitting NF; and/or
b) at the discharging hospital.

- If completed at the hospital, the entire Application form or only a portion may be done. When it is partially completed, the hospital must assure that:
  a) the following information is entered at a minimum:
     1) the applicant's name;
     2) home address;
     3) identifying information including Social Security number; and
     4) date of birth; and
     5) name and address of anticipated NF;
  b) the applicant and/or family is advised to contact the NF to complete the Application form; and
  c) a copy of the partially completed Application form is immediately forwarded to the admitting NF.

  Incomplete portions of the IPAS Application form must be completed at the NF within 24 hours of admission for "Direct from Hospital" authorized admissions.

  NOTE: Completion of the "agree/do not agree" and "authorization for release of information" portions are optional at the hospital. However, an individual who:
  a) is admitted to a NF under hospital discharge planner authorization;
  b) but "refuses to participate" after completion of the IPAS Application form at the NF;
  will be ineligible for Medicaid reimbursement, if needed, and will incur the IPAS penalty.

  The Application form must be completed within twenty-four (24) hours of designee-authorized NF admission and forwarded to the IPAS agency.

- The hospital discharge planner records his or her authorization:
  a) on the IPAS Application form in "Section II: Temporary Admission Authorization," "Direct from Hospital;"
  b) PRIOR to transfer to the NF;
  c) by checking appropriate boxes, entering applicable time frames, signing and dating the form. (Start date is the date of NF admission)

  "Direct From Hospital" authorization is only valid when Section II is appropriately completed.

- The hospital discharge planner must also check applicable statements in Section II that are listed directly below the "Types of admission."
  a) Medicaid MCO enrollee: If the applicant is enrolled in a Medicaid MCO, check the box to so designate and check the appropriate box for "Short-Term" or "Long-Term" anticipated NF stay. If MCO does not apply, leave the boxes blank.
  b) Nonresident statement: Only check the second statement if the applicant is:
     1) a nonresident in an Indiana hospital who:
     2) received treatment in the Indiana hospital's emergency room (ER); and
     3) was directly admitted and received treatment in the Indiana hospital's acute care bed. (See Chapter 3.9.2.)
  c) List of Long-Term Care Services: Check the box if the Indiana hospital has given to every patient who will be participating in IPAS:

1) the required list of long term care options;
2) available to the applicant;
3) located within the hospital's service area; and
4) known to the hospital.

- The discharge planner who completes the authorization must sign, date, enter the name and location of the hospital with which he/she is affiliated, phone number, and fax number.

  Either the NF and/or the hospital must forward it to the IPAS agency. The admitting NF has the responsibility to assure that the Application form is fully completed and that a copy is forwarded to the IPAS agency within five (5) working days.

  The hospital must assure that the NF receives the original of the fully or partially completed Application form. To expedite an assessment, which must be completed prior to hospital discharge, the hospital may also send or fax a copy of the fully completed Application form to the local IPAS agency.

- When the individual refuses to participate in IPAS while in the hospital, the hospital discharge planner CANNOT authorize NF admission. The IPAS Application "refuse to participate" portion must be completed. If the individual is admitted to a NF, he or she will incur the IPAS penalty. (See Chapter 6.2.)

3.7.3.3 Time Frame

"Direct From Hospital" admissions may be authorized for varying lengths of stay, judged on:
a) the attending physician's estimated time of recovery (ETR); and/or
b) the individual's Medicaid status.

Time frames are calculated from the date of NF admission.

a) Medicaid Recipients, Applicants, or Will-Apply (within 120 days): NF placement may only be authorized for a maximum of twenty-five (25) days for individuals who are Medicaid applicants, recipients, or will apply, regardless of presumed Medicare or other payment status.
b) Private-Pay Applicants (Non-Medicaid): NF placement may be authorized for the physician's Estimated Time of Recovery (ETR) plus twenty-five (25) days, not to exceed a maximum of one-hundred twenty (120) days.

The physician's ETR is the needed length of NF care designated by the physician. It will be based on the individual's level of functional impairment and prognosis for improvement.

3.7.4 Arrangement for NF Admission

The hospital discharge planner must provide necessary information for the NF to make an admission decision when the hospital discharge planner contacts the NF to arrange for a bed.

The NF must have sufficient information about the individual's condition and history to determine the patient's status and whether it (NF) can meet the individual's needs. This would normally include answers to questions about: diagnosis, medications, ADL impairments and need for care, suicidal or homicidal ideations and/or behavior problems, prior residence of individual, responses on Level I form and whether answers are correct, and any other information which may affect the NF's ability to meet the individual's needs.

3.7.5 Transmission of Documents to NF

All necessary hospital-completed IPAS and/or PASRR documentation must accompany the individual or be transmitted to the NF prior to admission. The NF must assure that all necessary documentation has been completed and placed on the individual's active record/chart.

3.7.6 IPAS Agency Acting As "Direct From Hospital" Designee

The IPAS agency will act as IPAS designee when:

a) a hospital refuses to exercise the option of acting as IPAS designee;
b) IPAS designee-status has been revoked; or
c) discharge is needed from a hospital-licensed (IC 16-21) hospital-based NF unit following a "substantially complete assessment."

Either the NF or the hospital may make referral for assessment directly to the IPAS agency.

Since the IPAS agency designee is not familiar with the individual or his or her needs, a "substantially complete assessment" is required. (See Chapter 4.3.1.) The IPAS agency must obtain enough information to perform the assessment which will require more time and review than the discharge planner's process.

3.7.7 Required NF Follow-Up

For "Direct From Hospital" admissions, the NF must assure that it:

a) receives the necessary paperwork from the hospital or from the IPAS agency, as appropriate;
b) reviews documentation (Application form, Level I, and so forth) for completeness PRIOR to forwarding it to the IPAS agency;
c) sends all necessary documents to the local IPAS agency (or assures that it has been sent by the hospital within 5 working days from the date of signature or, if the individual is admitted, from the date of admission, whichever is later; and
d) retains a copy of all documentation on the NF chart/file.

3.8 HOSPITAL-BASED NF UNITS

Some hospitals have hospital-based long-term care (NF) units. These units provide skilled (NF) level of nursing care and are located within the hospital. Such units may be called Extended Care Units (ECU), Transitional Care Units (TCU), Essential Care Services (ECS), or another label to differentiate them from acute care hospital beds.

SURVEY: These units are subject to survey by the ISDOH Long-Term Care Services Division, and must meet all NF criteria regardless of how they are licensed.

LICENSURE: Depending on factors such as who administers the unit, they may be licensed under either hospital licensure (IC 16-21) or NF licensure (IC 16-28).

In order to determine the relationship to IPAS and/or PASRR laws and regulations for these units, licensure and Medicaid certification status of each unit must first be determined.

3.8.1 IPAS Participation Requirement

IPAS law requires that hospital-based NF beds licensed under IC 16-28 must participate in IPAS for admissions and discharges.

To determine whether IPAS requirements apply, the licensure status of the hospital based NF unit must be established. The IPAS agency should:

a) check with the hospital unit; or
b) review the "Indiana Health Facilities Directory" published by the Division of Long-Term Care, Indiana State Department of Health (ISDH); or
c) call the ISDH, Division of Long-Term Care.

3.8.2 PASRR Participation Requirement

PASRR regulations require all Medicaid certified NF beds to participate. If the unit is Medicaid certified, it must follow PASRR requirements regardless of whether it is currently serving any Medicaid recipients or receiving Medicaid reimbursement. (See Chapter 10.3.) State licensure status is not a factor.

NOTE: The IPAS agency will log and update the status of hospital-based NF units in its area regarding IPAS and/or PASRR participation. (See the log in Appendix D, available on diskette from the State PASRR Unit.)

3.8.3 Differentiation between "Hospital-Licensed" and "NF-Licensed"

IC 12-10-12-3 specifies that IPAS applies to a nursing facility that is licensed under IC 16-28. by Therefore, a distinction must be made between hospital-based NF units with hospital licensure under IC 16-21 and those NF-licensure under IC 16-28.

The simplest method to determine how a hospital-based NF unit is licensed is to refer to listings in the Indiana Health Facility Directory published by the Indiana State Department of Health (ISDOH), Long-Term Care Program. "Hospital-licensed" units are listed at the back of the directory under the title page, "Hospital Based Long Term Care Units," usually around page 60. "NF-licensed" hospital-based NF units will be listed in the first part of the directory with NFs that are not hospital-based.

This differentiation is based not on survey activities, as all NF units must meet the same survey criteria. It is instead based on criteria established by the ISDOH entity which issues the license: either the Long Term Care Program (NF) or the Acute Care Division (hospital).

NOTE: The following criteria also apply to hospital-based NF units:

a) If the Unit is Medicaid-certified, Level I must be completed to determine PASRR status PRIOR to admission to the hospital's NF unit.
   (Then, if PASRR Level II is required, all IPAS and PASRR requirements for an individual needing PASRR Level II apply for the admission into the hospital-based NF unit.)
b) PASRR "Exempted Hospital Discharge" can only be used to authorize transfer from an acute care bed into a skilled (NF) care bed.

3.8.4 "Hospital-Licensed" (IC 16-21) Hospital-Based NF Unit

Admissions must follow requirements under the respective programs (IPAS and/or PASRR) which apply to the hospital-based NF unit.

- Admission: Admission to these units should use the following critera:
  a) IPAS-only (non-PASRR) admissions do not require IPAS designee authorization (However, these units may voluntarily participate in IPAS, if desired, for expeditious discharge to another NF.); or
  b) if PASRR is needed, only with "Exempted Hospital Discharge;" or
  c) with full IPAS/PASRR assessment and determination made PRIOR to admission.

- Discharge: The patient may be transferred to a NF bed licensed under IC 16-28:
  a) by using the time remaining on a Direct-from Hospital authorization made while in an inpatient acute care hospital bed*; or
  b) with PRIOR completion of the IPAS assessment and determination by the IPAS agency.

*NOTE: The hospital discharge planner cannot give Direct-from Hospital authorization after the individual has been admitted to the hospital-based NF unit.

3.8.5 "NF-Licensed" (IC 16-28) Hospital-Based NF Unit

A hospital-based NF-licensed unit must follow the same procedures as a freestanding NF.

- Admission: Admissions to these units may only be made:
  a) under IPAS-Only (non-PASRR) "Direct From Hospital" authorization made while the patient is in the acute care hospital bed; or
  b) if PASRR Level II is needed, under "Exempted Hospital Discharge;" or
  c) with full IPAS/PASRR determination.

NOTE: PASRR Exempted Hospital Discharge is only allowed for transfer from "acute inpatient care."

- Discharge to another NF Direct transfer to another NF licensed under IC 16-28 may be made when the following conditions are met:
  a) PAS 4B has been issued for full IPAS and, if applicable, PASRR, assessment; or
  b) authorized time remains from a "Direct from Hospital" authorization made while the patient was in the hospital's acute care bed.

The IPAS agency may find the table at Appendix D helpful when recording the status of the hospital-based NF units for the hospitals in its area.

3.8.5 Hospital "Medicare Swing Beds"

Medicare "Hospital Swing Beds" are hospital-based SNF level beds for post-hospital extended care services which meet the following criteria. The hospital:

a) is small, having less than 100 beds, excluding certain categories;
b) is in a "rural" area, not delineated as an "urbanized" area by the Census Bureau;
c) has a certificate of need for the provision of long-term care services from the ISDOH;
d) does not have in effect a 24-hour nursing waiver;
e) has not had a "swing-bed" approval terminated within 2 years prior to application;
f) a Medicare-participating SNF is not available or it has agreement with SNFs in its area which meet certain criteria; and
g) gives HCFA written assurance that it will not operate over 49 beds or over 99 beds except in connection with a catastrophic event. (Paraphrased from 42 CFR 482.66.)

3.8.5.1 "Swing Beds" and IPAS/PASRR

For IPAS and PASRR processing purposes, hospital Medicare Swing Beds will be treated as acute care beds.

IPAS bases its requirement for participation on licensure status. Swing Beds are hospital-licensed by the Acute Care Division at ISDOH. For PASRR, HCFA has only issued a statement that it was studying the application of PASRR requirements to swing beds. To date, Swing Bed regulations have not been modified to reflect PASRR.

The determination is that, at this time, neither IPAS nor PASRR are required for admission to Medicare Swing Beds. Discharge will follow hospital acute care criteria for IPAS and PASRR.

3.8.5.2 Identification of "Swing Bed" Status

To establish the Medicare "Swing Bed" status of a hospital-based unit, the IPAS agency should:

a) ask the hospital whether Medicare has approved it to provide post-hospital extended care services as specified under 42 CFR 409.30, and is it reimbursed as a swing-bed hospital as specified under 42 CFR 413.114;
b) ask the hospital if they are able to bill Medicare for these beds as "swing beds;"
c) refer to the Indiana Health Facilities Directory for a listing (Check both sections: if the hospital is not listed in either section and its unit has been operational for more than a year, it may be assumed that the unit qualifies as a "swing-bed." For example, Decatur County Hospital has a "swing bed" unit.); and
d) if still in doubt or unable to verify, call the Acute Care Division at ISDOH.

3.9 NONRESIDENTS

All out-of-state residents seeking admission to an Indiana NF must complete the entire IPAS assessment and receive the determination PRIOR to admission to the Indiana NF, except as specified in Chapters 3.9.2 and 3.9.3.

NOTE: DO NOT APPLY THE FOLLOWING CRITERIA IF THE APPLICANT REQUIRES PASRR LEVEL II ASSESSMENT, EXCEPT AS SPECIFIED IN CHAPTER 3.8.4. (See Chapters 10-16 for PASRR.)

3.9.1 Time Frame

ALL nonresident, IPAS-only (non-PASRR), applications must be completed within ten (10) calendar days following the appointment of the IPAS screening team.

Nonresident case processing time frames are calculated:
a. from the date that the IPAS screening team is appointed
b. to the date that the IPAS agency reports its findings.

For tracking purposes, the IPAS agency will
a) document the date that the IPAS screening team is appointed;
b) stamp all case documents with the required "date-received;" and
c) clearly explain in the case record the reason(s) for any delays, including all appropriate tracking dates.

The "date that the IPAS agency reports its findings" is defined to mean either:
a. the date that the IPAS agency issues its determination on PAS Form 4B for private-pay applicants; or
b. the date that the IPAS agency faxes the case with its recommendation on PAS Form 4A to OMPP or the State PASRR Unit.

It is important for the IPAS agency to record these dates on either the PAS Form 4A or 4B. A record of these dates and delays may be pertinent to appeals and/or waiver of the IPAS penalty requests.

3.9.2 Refusal to Participate in IPAS

A nonresident who does not require Level II may:
a) refuse to participate in IPAS;
b) be admitted to an Indiana NF; and
c) incur the IPAS penalty.

NOTE: The IPAS agency must obtain as much documentation as possible to support a decision that PASRR Level II is not required. The Level I completion will usually not be enough. The case record must describe in detail the efforts and results to verify that PASRR Level II is not needed.

3.9.3 Nonresidents and Indiana NF Temporary Admissions

An IPAS agency cannot authorize temporary admission to an Indiana NF except under Chapter 3.9.4.

PRIOR to authorizing a temporary admission a full IPAS assessment and determination must be completed.

- After the full IPAS assessment and determination are completed and admission under IPAS approved, the IPAS agency may authorize IPAS "30-Day Short-Term."
- After the full IPAS and PASRR assessment and determination are completed and NF admission approved, the IPAS agency may authorize PASRR "Exempted Hospital Discharge" (unless the provision in 3.9.2, above, is used), or PASRR "Respite."

As soon as it is found during the temporary stay that the individual's condition/circumstances have changed so that he or she now requires a longer NF stay:
a) the NF must immediately notify the IPAS agency;
b) a verbal notice from the NF must be followed by a written explanation to the IPAS agency fully explaining the nature of the change which now makes long-term placement necessary;
c) the PASRR Level II must be updated, if required due to a change in MI and/or MR/DD condition, following instructions in Chapter 13; and
d) the IPAS agency will update the IPAS case packet and redo the IPAS determination, as applicable.

The IPAS agency may recommend:
a) an extension of the short stay; or
b) if warranted, long-term placement.

3.9.4 "Indiana Resident" in an Out-of-State Hospital

An Indiana resident seeking admission to an Indiana NF from an out-of-state hospital qualifies for authorization for "Direct from Hospital" admission if the Indiana resident:
a. is participating in IPAS; and
b. has received treatment in the acute care bed of the out-of-state hospital; and
c. is being discharged directly from the hospital into an Indiana NF; and
d. has received authorization by the IPAS agency designee.

NOTE: An out-of-state hospital discharge planner CANNOT authorize admission to an Indiana NF under any circumstances.

3.9.5 Nonresidents in an Indiana Acute Care (Hospital) Bed Following Treatment in the Indiana Hospital's ER

A change in Indiana law effective July 1, 1997 allows a nonresident to be admitted to an Indiana NF directly from the Indiana hospital under the following circumstances:
a. the nonresident received treatment in an Indiana hospital's emergency room (ER);
b. the nonresident was admitted to the Indiana hospital acute care bed after receiving treatment in the Indiana hospital's emergency room (ER); and
c. the applicant received treatment from and is being directly discharged from the Indiana hospital's acute care bed; and
d. the applicant is participating in IPAS.

The IPAS agency or Indiana hospital discharge planner:
a) may authorize "direct from hospital" admission when the above conditions are met; and
b) must certify on the IPAS Application form, revised 1/98 or later, that the qualifying criteria applies by checking the appropriate statement below the check box for Direct from Hospital authorization.

NOTE: When an Application form is used which does not have the necessary certifying statement, the Indiana hospital discharge planner (or IPAS agency based on the information from the hospital discharge planner) will write the statement in Section II of the form.

To expedite processing, the hospital:
a) should begin discharge planning on the day an individual is admitted; and
b) may assist the IPAS agency by providing as much completed documentation as possible including, but not limited to:
   1) completion of the PASRR Level I and IPAS Application forms;
   2) having the doctor complete and sign the Physician Certification for Long-Term Care Services (Form 450B); and
   3) helping in any other way feasible.

3.9.6 Other IPAS Agency Requirements

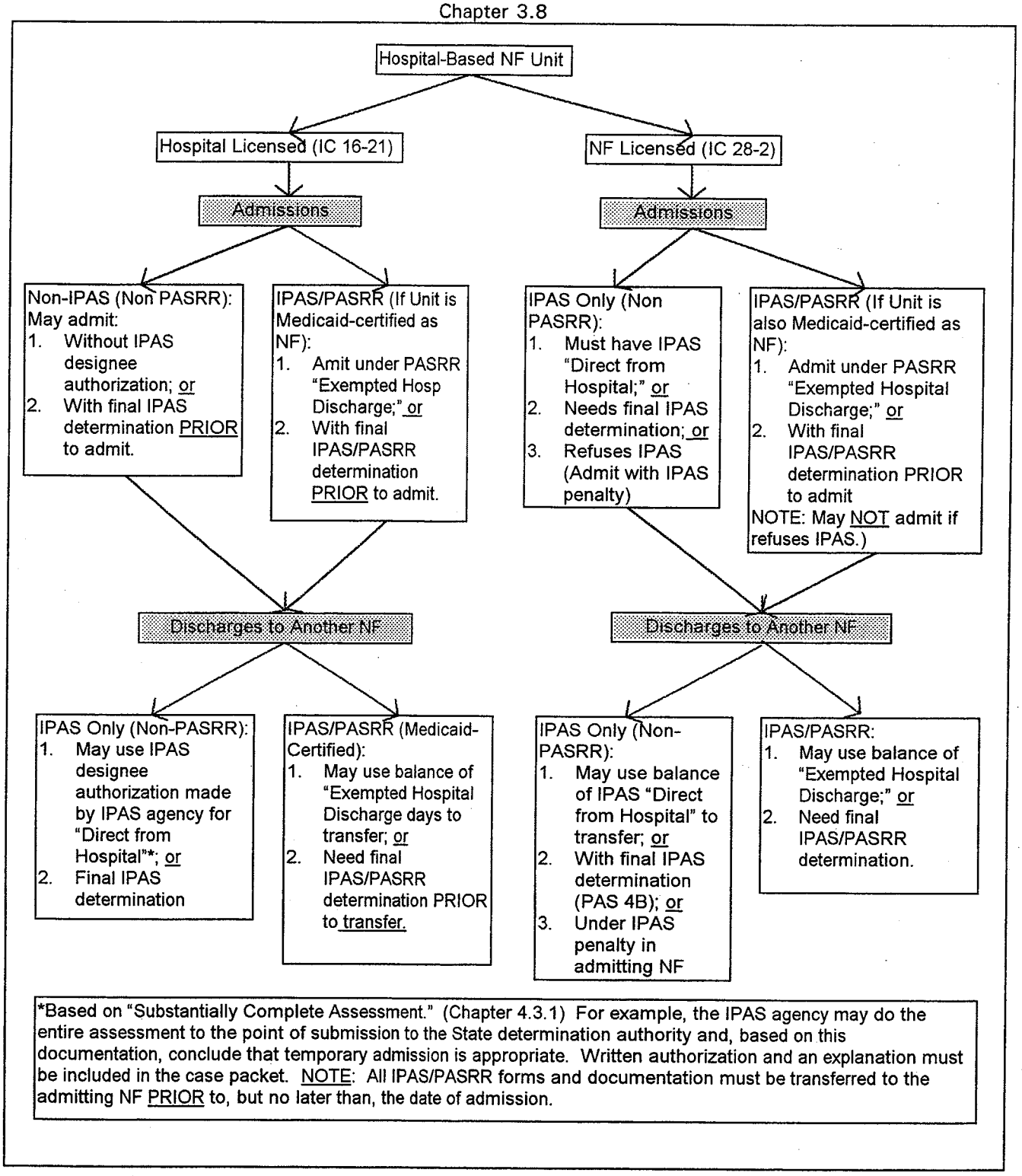
For Medicaid data purposes, the IPAS agency must:
a. always inquire and record in the case record the reason a non-resident desires to enter an Indiana NF; and
b. maintain a log system identifying applications by out-of-state residents, including at a minimum: the original state of residence; Medicaid status in the other state; intended Medicaid status in Indiana; reason for seeking NF placement in Indiana; and case disposition.

When the applicant is in a NF out-of-state, the IPAS agency must obtain 30 days of the most recent NF chart information, including copies of nurses' notes, physician's orders and progress notes, and social service notes as part of the IPAS assessment.

3.9.7 Residency Determination

For purposes of the IPAS program only, an individual is considered an Indiana resident if he or she currently resides in Indiana or resided in Indiana immediately prior to hospitalization out-of-state. An Indiana resident seeking admission to an Indiana NF from an out-of-state hospital is treated as if he or she resides in Indiana.

HOSPITAL BASED NF UNITS
Chapter 3.8



*Based on "Substantially Complete Assessment." (Chapter 4.3.1) For example, the IPAS agency may do the entire assessment to the point of submission to the State determination authority and, based on this documentation, conclude that temporary admission is appropriate. Written authorization and an explanation must be included in the case packet. NOTE: All IPAS/PASRR forms and documentation must be transferred to the admitting NF PRIOR to, but no later than, the date of admission.

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IPAS & PASRR MANUAL

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Chapter 4

IPAS ASSESSMENT

The purpose of the IPAS assessment is to determine:
(1) the appropriateness of an individual's placement in a NF;
(2) whether community-based services are available which would meet the individual's needs; and
(3) a cost-comparison analysis of community-based versus NF care.

4.1 IPAS SCREENING TEAM

A screening team consisting of at least two (2) members for each applicant conducts the IPAS assessment. It must include:

a) the applicant's attending physician will participate as a member of the team.
b) the IPAS agency, subject to approval by the State, will appoint an individual who:
   1) represents the IPAS agency serving the area in which the applicant's residence is located; and
   2) is familiar with personal care assessment; and
   3) meets the qualifications specified at 460 IAC 1-1-10(c) or (d). (See Appendix ___.)

   The IPAS agency will assure that each appointee meets these requirements and will maintain documentation of the qualifications for State audit purposes. One approved individual will be appointed to be the Screening Team Coordinator.

c) Additional team members:
   1) may be appointed to the Team, if the IPAS Team Coordinator deems it necessary;
   2) should either meet the requirements above; or
   3) be able to provide specialized knowledge pertinent to the assessment of an individual's needs for IPAS purposes.

As the Team has the responsibility to act in a timely manner, and members of the Team may vary with each applicant, the Team will of necessity function as an informal unit

NOTE: The IPAS assessment and determination will be completed as soon as possible, but no later than twenty-five (25) days from the date of application, unless a different time frame applies for temporary admissions. (See Chapter 3.)

4.1.1 Appointment

The Team will be appointed by the IPAS agency that serves the county in which the applicant resides at the time the complete IPAS assessment is conducted. When an applicant resides out of state, the team will be appointed by the IPAS agency that serves the county in which the anticipated NF is located.

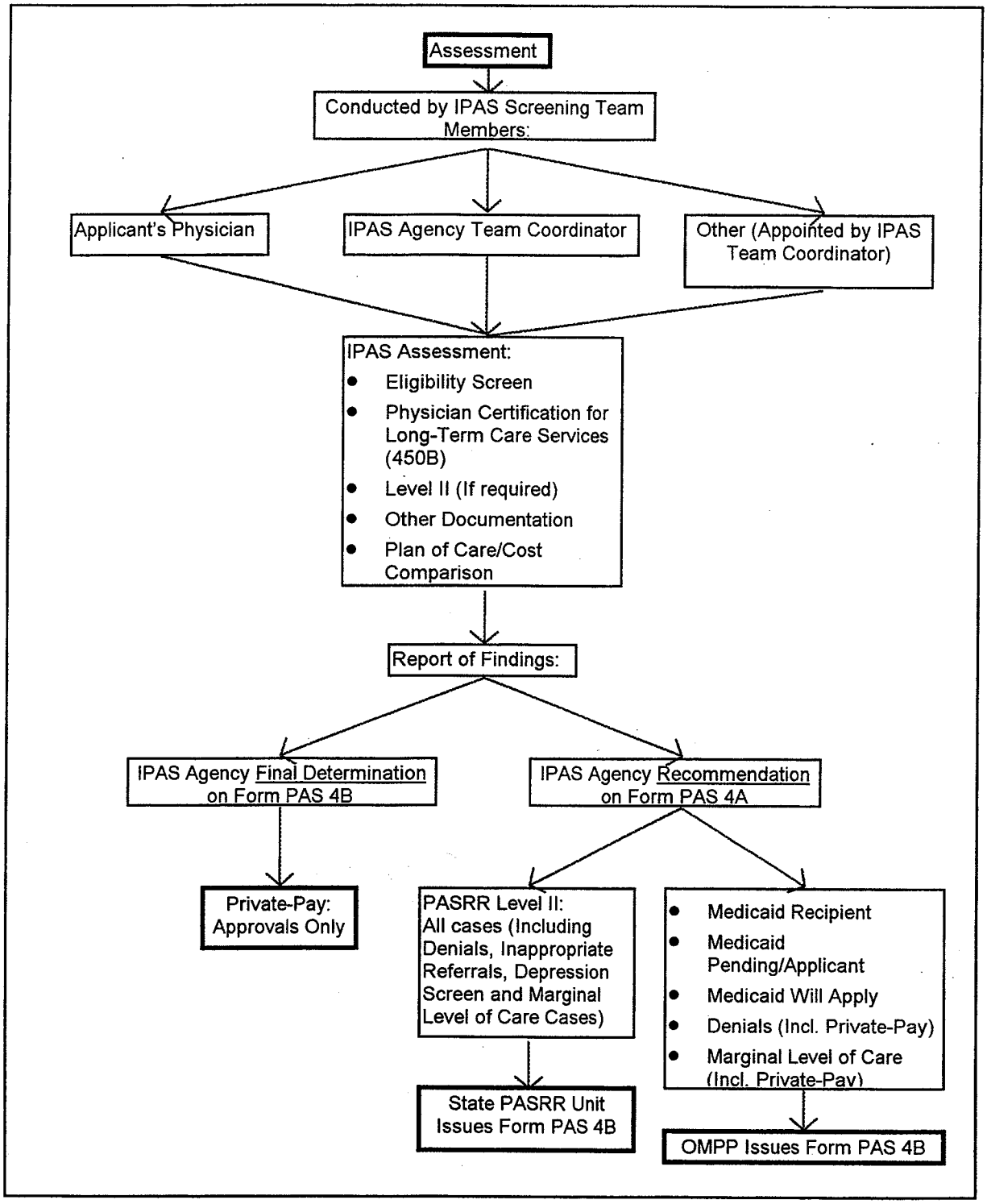
More than one (1) team per area may be appointed.

4.1.2 Duties

The IPAS Team will conduct the IPAS assessment according to the policies and procedures prescribed by DDARS. (See Chapters 4.2, 4.3, 4.4 and 4.5.)

After the IPAS assessment is completed, the members of the IPAS Team will review all case documentation. The IPAS Team will vote:

a) on whether NF placement is appropriate according to IPAS (and, if required, PASRR) criteria, using criteria consistent with Medicaid requirements;
b) either by signature at the time of individual team member contact, or by telephone;
c) using the physician team member's completion of and signature on the Form 450B, unless he/she wishes to be more active in IPAS Team activities.



4.1.3 Submission of Findings

The findings and recommendation of the IPAS Team will be recorded on the PAS Form 4A, Recommendation of Screening Team. (See Chapter 4.6.)

The recommendation on the PAS 4A form will be:

a) considered to be for "long-term placement;"
b) unless a time-limited "short-term" stay approval is indicated that specifies the applicable time period; and/or
c) modifies the stay by indicating that a follow-up assessment should be done after a specified length of time.

4.2 CONDUCTING THE ASSESSMENT

The IPAS agency will follow accepted standards of case assessment, incorporating factors pertinent to the IPAS program.

4.2.1 Personal Interview/Visit with Applicant

A face-to-face visit with the applicant:
a) is always required;
b) unless the applicant is currently residing out-of-state; and.
c) results of the visit will be adequately recorded in the case record.

(Nonresident applicants currently in an Indiana hospital, however, must be visited as part of the assessment.)

4.2.2 Nonresident Applicants

The assessment of an applicant who is living out-of-state may be conducted via telephone. The IPAS assessor will speak with:
a) the applicant and/or guardian (whenever possible); and
b) persons knowledgeable about the applicant's condition and situation, including family members and/or interested persons;
c) persons in medical and/or other significant support positions; and
d) other persons in pertinent roles.

Information obtained via telephone will be documented and specifically identified, noting that it was received over the telephone. The relationship of the respondent to the applicant must be noted.

NOTE: The IPAS agency will clearly record in the IPAS case the reason for the request to move to an Indiana NF. This data will be maintained at the IPAS agency and reports filed with the State authority(ies), as requested.

4.3 CONTENT OF ASSESSMENT

The IPAS assessment:
a) is a comprehensive evaluation of an individual's short and/or long-term medical care and psycho-social needs;
b) culminates in a judgment of the appropriateness of short or long-term NF placement; and
c) makes a judgment whether NF placement can be offset by the availability of alternative community-based services to meet identified needs.

The IPAS assessor will record:
a) pertinent information and impressions from the interview, including the physical environment when an at-home assessment is conducted;
b) barriers to continued at-home placement;
c) information elicited from other individuals familiar with the applicant and his or her needs, identifying all sources of information; and
d) the applicant's condition at the interview on the Eligibility Screen when the applicant is unable to respond or cooperate with the interview.

If the applicant is in a hospital, NF, or out-of-state, questions should be phrased so that responses will reflect what the applicant's needs would be if he or she were at home or in a residential living environment.

NOTE: Do not state that a need is met because the hospital or NF provides the care. This is redundant.

Two (2) types of assessment are specified in the IPAS law:

a) a "substantially complete assessment" is a partial assessment process which collects sufficient information on the medical and psycho-social needs of the individual to determine that, prior to a final determination, temporary NF placement is appropriate; NOTE: It is used for "Direct from Hospital" designee authorization. (See Chapter 3.7.1.)
b) a "complete assessment" is a full assessment which culminates in a final determination of the appropriateness of NF admission for either short or long-term placement.

4.3.1 "Substantially-Complete Assessment"

IC 12-10-12-28 allows admission of a non-PASARR Indiana resident directly to a NF from acute (non-psychiatric) care in an Indiana licensed hospital under the following circumstances:

a) a substantially complete assessment has been completed; and
b) based on the assessment results, the IPAS designee makes a finding that services necessary to care for the individual outside the hospital are not at that time available except in a NF, at least for a short-term.

The "substantially complete assessment" must contain enough medical, psycho-social, functional impairment, and related needs information to make a judgment that at least temporary NF placement is needed.

Either the hospital discharge planner or the IPAS agency may act as designee for Direct-from-Hospital authorizations.

4.3.1.1 Hospital Discharge Planner Designee

Completion of the requirements under 42 CFR 482.43 assures that the hospital discharge planner meets the IPAS requirements for a "substantially complete assessment."

For "Direct from Hospital" authorizations, the IPAS agency may appoint the hospital discharge planner(s) to act as IPAS designee:

a) following procedures in Chapter 3.7; and
b) based on the hospital discharge planning evaluation required by 42 CFR 482.43 used to constitute the "substantially complete IPAS assessment;" (See Appendix J.) and
c) including a copy of the applicable discharge planning evaluation in the patient's medical record transferred to the NF with the patient.

The results of the hospital's evaluation will be reviewed by the NF and used for the individual's NF plan of care. The IPAS assessor should also review it when a complete IPAS assessment is subsequently conducted.

4.3.1.2 IPAS Agency Designee

If the IPAS agency is acting as designee for "Direct from Hospital" authorizations (Chapter 3.7.6), the IPAS agency's designee will need to:

a) obtain sufficient information to constitute a "substantially-complete IPAS assessment" (Chapter 4.3.1) on which to base the decision for NF temporary placement, reviewing the hospital's discharge planning evaluation as part of the decision-making; and
b) make a decision to authorize "Direct-from-hospital" temporary admission prior to submission of the IPAS case packet to the OMPP for final determination, if the individual is Medicaid and non-PASRR; or
c) do a complete IPAS assessment and make a final determination, when the individual is private-pay non-PASRR.

4.3.2 "Complete Assessment"

The assessment will be conducted using assessment forms developed and approved by DDARS. A complete IPAS assessment will, at a minimum, consist of the following:

a) demographic information necessary to identify the individual and his or her situation;
b) documentation of the current overall medical/physical and mental health condition of the individual;
c) information on the current psychosocial and related service needs of the individual;
d) evaluation of the individual's current degree of functional impairment and related service needs (based on performance of ADLs and the ability to perform ADLs, not the refusal to perform them);
e) identification of the current unmet necessary service needs of the individual which, if they continue to be unmet, would result in placement in a NF;
f) identification of formal and informal necessary services that are presently available to meet identified unmet service needs, listing both those currently being utilized and those not currently used or provided to the individual;
g) record of IPAS assessor's observations during the on-site visit;
h) record of other persons consulted during the assessment, including pertinent observations;
i) documentation of the individual's preference of care, regardless of agreement to enter the NF; and
j) construction of an IPAS care plan which includes cost comparisons.

Documentation may be drawn from various sources, including the physician, family, hospital discharge planner, case manager, and other care/service providers. The IPAS Team will collate all pertinent documentation as part of an IPAS case packet.

4.4 FORMS TO RECORD ASSESSMENT AND TEAM ACTION

The following IPAS forms, at a minimum, will be used to document the assessment findings of the IPAS Team:

a) certification of the need for PASRR Level II on the PASARR Level I, Identification Evaluation Criteria (State Form 45277/Form 450B Sect. IV-V);
b) authorization of temporary NF admission on the Application for Long-Term Care Services (State Form 45943/BAIS 0018);
c) documentation of medical need on the Form 450B, Physician Certification for Long-Term Care Services, Sect. I-III (State Form 38143);
d) if an MR/DD condition, documentation of additional medical information on the Physician Certification for Long-Term Care Services and Physical Examination for Level II (State Form 45278/ Form 450B, Section VI);
e) assessment of need for care and functional impairments on the Eligibility Screen, ASD 013 (State Form 45528);
f) if a mental illness condition, the PASRR-MI Level II Assessment of Mental Health (State Form 43064) or, if a condition of MR/DD, the PASRR/MR/DD Assessment
g) other (Other pertinent documentation); and
h) record of the IPAS Screening Team's vote on the PAS Form 4A, Recommendation of Screening Team (State Form 706).

4.5 CARE PLAN AND COST COMPARISON

The last part of the IPAS assessment is the formulation of a care plan and the required cost comparison between community-based services and NF services.

4.5.1 Care Plan

The Eligibility Screen and other assessment information should result in a comprehensive, individualized plan of care, functioning to identify necessary alternative services and to perform the cost comparison requirement of IC 12-10-12-19(2). The plan of care will:

a) record the service plan;
b) identify gaps in service;
c) record the quantity and cost of necessary formal and informal long-term care services (in-home, community-based and facility-based);
d) compute the cost comparison; and

e) compute the percentage by which community care costs exceed the cost of NF care.

The IPAS agency will assure that the care plan is appropriately documented in the IPAS case record.

For an individual who has first been determined to need the NF level of services, IC 12-10-12-19 stipulates that NF placement may not be denied if:

a) community services that would be more appropriate than care in a NF are not actually available; or
b) the cost of appropriate community services would exceed the cost of placement in a NF; or
c) the applicant who is a current recipient of Medicaid Waiver Services chooses to be admitted to a NF. (See Chapter 7.)

4.5.2 Cost Comparison Computation

In order to establish the IPAS cost comparison, the cost of necessary home and/or community-based services will be:

a) computed and compared to the cost of NF care;
b) compared to the cost of non-institutional care; and
c) information on the availability and cost of alternative services provided:
   1) to the individual and/or the representative for possible use; and
   2) to authorized entities involved in establishment and provision of alternative services.

4.5.3 Identification of Alternative Services

The IPAS agency should provide Information to the individual and/or appointed representative on available home and community-based services not being used, but identified during the IPAS assessment.

4.6 IPAS TEAM RECOMMENDATION ON ~~FORM PAS 4A~~

After an IPAS assessment is complete, the IPAS Screening Team will make a formal recommendation of its findings. NOTE: The IPAS Screening Team makes a "recommendation" to the appropriate determination authority. This recommendation will not be construed to constitute the "final determination."

4.6.1 Review of Assessment Documentation

The IPAS Screening Team will perform the following functions:

a) review the IPAS assessment records and documentation; and
b) make a finding based on need for care including need for NF level of services (using Medicaid criteria); and
c) if there is a medical need for NF level of services, consider the availability of alternative home and/or community-based services to offset the need for a NF and compare the cost of alternative services to the cost of NF institutional care.

4.6.2 Recording the Vote

Following the case review, the IPAS Team will record the vote of each member of the IPAS Screening Team on form PAS 4A.

a) The vote may either be made by a signature at the time of individual contact, based on a review of all necessary IPAS data, or the vote may be conducted by telephone and recorded by the IPAS agency Coordinator.
b) Although the vote of the physician Team Member is made by completion of and signature on the Form 450B, the physician may opt at any time to participate more actively as a Team member.

The vote of the IPAS Screening Team constitutes a formal recommendation of the appropriateness of NF placement to the IPAS agency.

NOTE: The form PAS 4A also records other pertinent information or decisions which apply to the determination process such as:

a) recommendations for time-limited stays (including beginning and ending dates);
b) type of designee authorization or exclusions used;
c) Class A infractions;
d) IPAS penalty periods; and
e) other items significant to the determination process should be listed.

4.6.3 "NF Placement Is Inappropriate"

If the IPAS Team finds that placement in a NF should be denied, the recommendation on the PAS 4A form will:

a) list the reason(s) for denial, including but not limited to:
   1) does not have the need for the level of services provided in a NF; and/or
   2) needs specialized services identified through a PASRR Level II assessment; and
b) list identified, available alternative community-based services:
   1) detail the source/provider and cost of those community services, regardless of the source of payment; and
   2) detail the cost of placement in a NF (which will include the cost of all services, including those costs in addition to per diem which the applicant will require), regardless of the source of payment.

The assessor will:

a) discuss any alternative services identified in the course of the assessment with the applicant or his or her legal representative;
b) answer any questions involved with the IPAS assessment; and
c) put all findings in writing.

4.7 PREPARATION AND DISPOSITION OF CASE PACKET

The IPAS agency team member will:

a) prepare the contents of the case packet in the order specified below using documentation listed in Chapter 4.4;
b) submit the IPAS and/or PASARR Case Packet to the appropriate determination authority as soon as possible, but no later than five (5) days prior to the expiration of the designee authorized time limit;
   1) fax the IPAS-Only Medicaid recipient/applicant/will apply and denial/marginal case packet to the State OMPP;
   2) fax the PAS/PASRR (including Level II deferral and inappropriate) case packet to the State PASRR Unit for determination; and
   3) make the determination and issue the PAS 4B for private-pay/non-PASRR cases.

The IPAS agency will clearly explain the reason for any delays in meeting the required time frame in the case record. It should list the date of IPAS application, the type of IPAS case (from home or type of designee-authorized temporary admission), all applicable dates (including specific dates of designee-authorization) and a statement of circumstances causing the delay.. Cases pended beyond applicable time limits, without legitimate explanation of the delay, may be subject to post-audit penalty.

Order of documents in the IPAS/PASARR Case Packet, from top to bottom:

a) PAS Form 4A, Recommendation of Screening Team (State Form 706)
b) Form 450B, Physician Certification for Long-Term Care Services, Sect. I-III (State Form 38143)
c) (If MR/DD referral) Physician Certification for Long-Term Care Services and Physical Examination for Level II, Section VI (State Form 45278)
d) Form 450B, PASARR Level I, Identification Evaluation Criteria, Sect. IV-V (State Form 45277)
e) If PASARR, Assessment of Mental Health/PASARR-MI Level II or MR/DD Assessment (State Form 43064)
f) ASD 013 Eligibility Screen (State Form 45528)
g) Application for Long-Term Care Services (State Form 45943/BAIS 0018)

Chapter 5, IPAS Final Determination, describes the process, forms distribution, and other factors connected to the final determination.

NOTE: At the conclusion of the case, the IPAS agency will assure that Form 4B: Assessment Determination (State Form 707), along with the PASARR Certification Determination (State Form 47176/BAIS 0032) form, when applicable, is attached to the top of the case packet when the case is stored in its files.

IPAS & PASRR MANUAL

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Chapter 5

IPAS FINAL DETERMINATION PROCESS

When the IPAS assessment and IPAS Screening Team recommendation are complete, a final determination of appropriateness for NF placement will be made.

5.1 FORM PAS 4B

EVERY RESIDENT OF AN INDIANA NF MUST HAVE A PAS FORM 4B ON THE NF CHART. The PAS Form 4B:

a) records the patient's status regarding IPAS compliance; and
b) proves that the NF complied with the IPAS law requirement in Chapter 2.3.1.

The form PAS 4B, Assessment Determination, records the final determination for the IPAS and/or PAS portion of the PASRR programs. (For PAS/PASRR, form PAS 4B is always used in conjunction with the PAS/PASRR Certification form.)

All pertinent information recorded on the form PAS 4A, Recommendation of Screening Teams, will be transferred to the PAS 4B by the determination authority, unless it does not apply.

A final determination is:

a) valid for 90 days from the date of issuance of the PAS Form 4B as long as:
   1) the individual has not been admitted to a NF; or
   2) his/her condition has not improved to the extent that NF admission is no longer needed;
b) valid for only one admission. THE 90-DAY ALLOWANCE EXPIRES WITH NF ADMISSION. A full or updated IPAS assessment must be done again if an individual who has been admitted to a NF leaves or is discharged to home and seeks readmission prior to the expiration of the 90 days,. (See Chapter 5.5.)

5.2 CASE TERMINATION PRIOR TO FINAL DETERMINATION

A case may be terminated prior to final determination by the local IPAS agency, the OMPP, or the State PASRR Unit. (Also see Chapter 2.6.4.)

Reasons for case termination include, but are not limited to, the following:

a) voluntary withdrawal by the applicant;
b) lack of cooperation by the applicant or legal representative;
c) death of the applicant;
d) discharge from the NF to home or living arrangement;
e) identification of an IPAS penalty which is still in effect;
f) concurrent IPAS case processing by another IPAS agency (See Chapter 2.4 and 3.1.); or
g) another appropriate reason.

The "NF discharge date" is the date on which the NF record is closed and/or the last date for which the NF may bill Medicaid.

NOTE: Never pend a case beyond applicable time limits because an individual cannot make a decision or has changed the decision to continue to seek NF placement. The case should be terminated due to voluntary withdrawal, refusal to participate, or failure to cooperate, as applicable.

An IPAS application should not be pended beyond applicable IPAS and/or PASRR processing time frames, unless the following applies:

a) the applicant has been discharged to an acute care hospital bed with the expectation that he or she will return to the NF following hospital discharge;
b) there is a "Medicaid 15-day bed hold" or a leave of absence during which the NF record is held open and the bed held for a patient's return; or
c) the physician, hospital, or NF fails to provide necessary documentation; or
d) another appropriate reason applies.

The IPAS agency will clearly document, on the PAS Form 4A, the reason an IPAS and/or PASRR case is pended, clarifying the applicable dates. When termination is due to voluntary withdrawal or failure to cooperate, the individual should be advised that he or she can reapply. (Also see Chapter 5.6 for limits on reapplication.)

5.3 IPAS CASE REVIEW AND DETERMINATION PROCESS

The IPAS agency, OMPP or the State PASRR Unit makes final determination. The entity responsible for making the final case review and determination is based on the individual's status: private-pay, Medicaid eligible/applicant/will-apply, denial, marginal, or PASRR.

5.3.1 Non-PASRR Medicaid, All Denial and Marginal Cases

The State OMPP is responsible for final determination for non-PASRR:
a) Medicaid recipients, applicants, or will apply for Medicaid within 120 days;
b) denial cases; and
c) marginal cases on which the Screening Team disagrees or is unable to make a determination.

5.3.2 PASRR Cases

The State PASRR Unit is responsible for final determinations for all PASRR cases, regardless of other factors, including the following:
a) deferred cases;
b) Level II Inappropriate Referral cases. (Under certain conditions, the Inappropriate Referral form is used by the CMHC in lieu of completion of the Level II.)

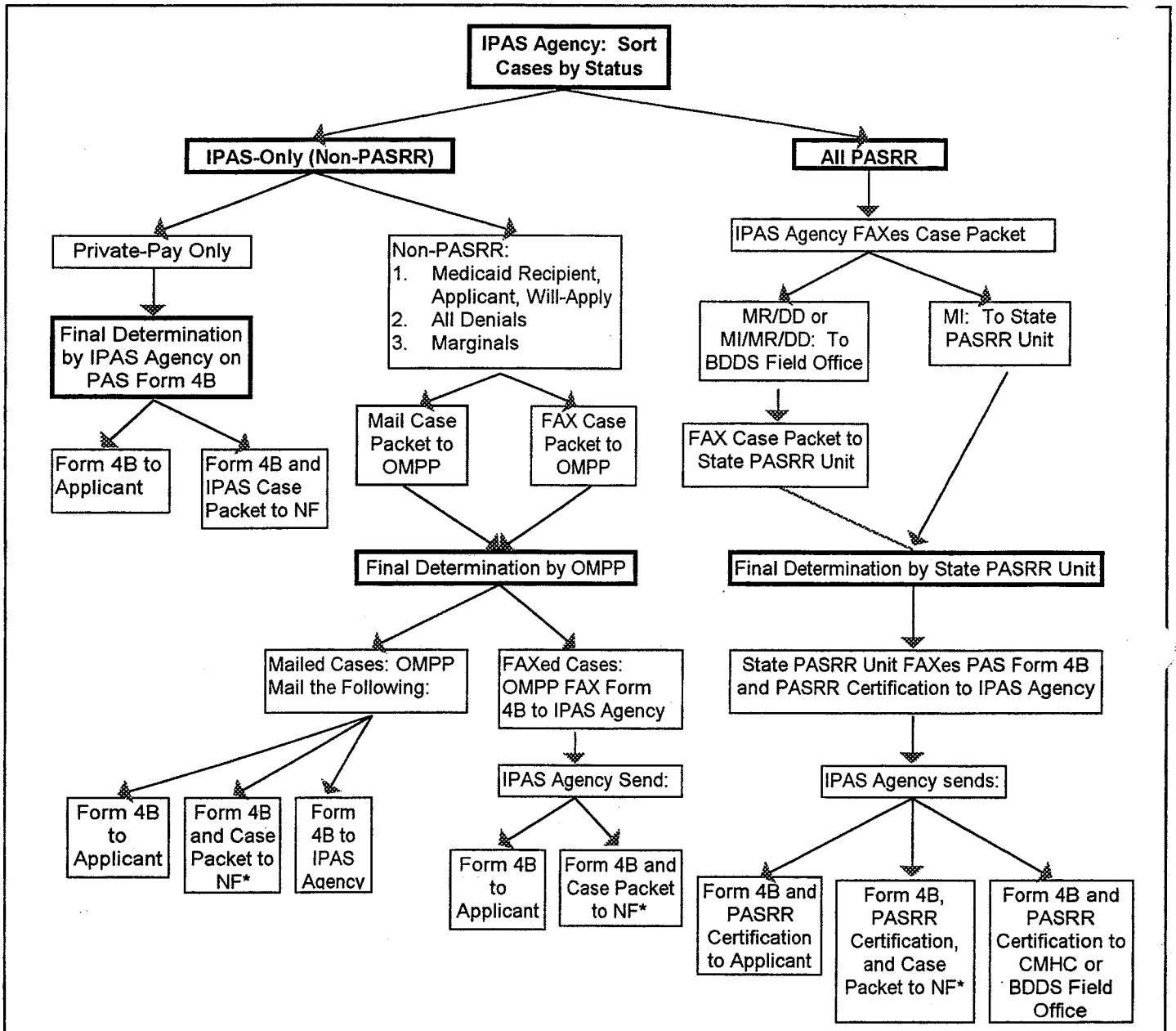
Level II assessment may be deferred or delayed due to:
a) inability of the individual to cooperate in the assessment because of a state of delirium or coma; and
b) results of a Depression Screen which indicates that the depression has been both of short duration and mild intensity. When the IPAS agency uses the Depression Screen and does NOT make a referral for Level II, the IPAS agency will assure that the following caveat is entered on the PAS 4A form for transfer to the PAS Form 4B by the State PASRR Unit:

"Level II is not completed at this time although the above-named applicant's condition would ordinarily require PASRR Level II assessment. It is the responsibility of the NF to monitor the individual's condition. If the condition of behavior or mood either worsens, or has not improved, within the 90 days following NF admission, the NF will make a referral to the local CMHC for a non-routine ARR." (Caveat is also printed on the back of the Depression Screen form.)

5.3.3 Non-PASRR Private-Pay Cases

The local IPAS agency will issue the final determination for private-pay cases not covered by the categories above. The IPAS agency will use criteria of need for NF level of services which is consistent with that used by OMPP and the State PASRR Unit.

PROCESSING FOR FINAL DETERMINATION
Chapter 5



***NOTE:** When no NF has been designated by the applicant, the case packet with the PAS Form 4B and PASRR Certification will be retained by the IPAS agency until notification is received that a NF is chosen. The entire IPAS and/or PASRR case packet will then be forwarded to the designated NF for retention on the resident's chart.

A NF admitting an individual is responsible to contact the IPAS agency serving the area of the individual's home residence to obtain necessary approvals and documentation.

5.4 RECORDING THE IPAS FINAL DETERMINATION

Every valid IPAS Application form will receive a final determination. The IPAS/PASRR final determination is recorded on:

a) form PAS 4B for IPAS-Only; or
b) two (2) forms, form PAS 4B and the PASRR Certification, for PASRR. (For PASRR, both forms will be used together.)

The form PAS 4B may include specific limitations and/or recommendations. The PASRR Certification may contain specific service recommendations which will be addressed in the individual's Plan of Care by the NF.

5.5 DETERMINATION IN EFFECT FOR 90 DAYS

For an individual who has not entered the NF, the PAS approval for NF admission remains in effect for ninety (90) days, provided that the individual's condition or situation remains the same or has not improved to the extent that NF placement is no longer needed.

When the ninety (90) day PAS approval time limit has expired, but NF placement is still needed, the IPAS agency will:

a) update the case record; and
b) determine the reason that the individual was not admitted within the time limit; and
c) document this reason in the case record; and
d) resubmit the case for IPAS and/or PASRR approval PRIOR to NF admission.

All pertinent case records will be updated either by:

a) clearly marking the case with "Remains the Same;" or
b) supplementing it with new documents so marked and attached to the front of the old case record; and
c) initialing and dating the case record by the individual submitting the materials; and
d) including a cover letter explaining the circumstances and need for a new determination.

The updated case record will be processed as soon as possible. A new Form PAS 4B will be issued with a notation explaining the update.

5.6 FURTHER IPAS SCREENINGS PERMITTED

For individuals who have undergone the IPAS assessment and have been determined to be inappropriate for NF placement:

a) no further IPAS screenings may be requested by that individual for a minimum of one (1) year;
b) unless the medical condition or the support system of the individual is significantly changed to the degree that the attending physician certifies, in writing to the IPAS agency, that a new screening process is medically necessary. → New 450B

The physician's certification will describe the specific nature of the pertinent change(s) and how it differs from the previous condition.

The IPAS agency will:

a) make the final decision on the need for another IPAS assessment based on the attending physician's certification; and
b) date-stamp the physician's certification with the date-received; and
c) enter it's certification of the need for a new IPAS assessment in the case.

The effective date of the IPAS Application for additional assessment will be the date of the physician's certification.

The IPAS agency will process the case by:

a) attaching the physician's written certification and the IPAS agency's certification to the top of the new IPAS case, with a copy of the previous IPAS case record attached;
b) clearly marking new documents to differentiate them from the old case documents; and
c) following all appropriate procedures for a new IPAS assessment and determination.

5.7 REFERRAL FOR CASE MANAGEMENT SERVICES

It is presumed that individuals who apply for NF placement may, if not admitted to the NF, be anticipated to be in a situation of possible jeopardy.

For all denied cases, the IPAS assessor or coordinator will:
a) make bona fide referral of the individual to available case management services; and
b) provide information on the assessment and necessary service needs identified through the IPAS assessment and care-planning to case management as part of the referral.

If no case management service is available or the individual does not meet eligibility criteria, the IPAS coordinator should assure that:
a) the applicant or his/her representative receives all service information which may have resulted from the IPAS assessment and care plan; and
b) provide enough detail so that the individual or interested representative will be able to pursue service acquisition.

5.8 DOCUMENTS: AVAILABILITY, CONFIDENTIALITY, DISPOSITION, AND RETENTION

5.8.1 Availability

Except as specified below, IPAS case documents may only be released with written authorization from the applicant or his or her legal representative.

IPAS case records are provided to the applicant, or his or her legal representative, upon written request. For purposes of individual care planning and service provision, Medicaid requires that the IPAS case record be provided to the NF to which the individual is admitted. Other state and federal programs, audits and surveys may have access to the IPAS case records as specified by law.

See Chapter 12.3.1 of this Manual for special PASRR Level II program provisions on availability of records to physicians, hospitals and individuals.

5.8.2 Confidentiality

Retention, access to, and distribution of IPAS case records will follow and maintain confidentiality in accordance with all pertinent state and federal laws and regulations.

5.8.3 Disposition

After IPAS final determination, the IPAS agency will distribute case records as follows:
a) the entire case record packet on which the IPAS determination is based is sent directly to the appropriate NF for retention on the NF active chart;
b) the entire case packet will be readily available to the state and federal auditors and surveyors; and
c) the form PAS 4B will be appropriately distributed with a copy sent to the CMHC or D&E Team by the IPAS agency when PASRR was required.

When there is a transfer between NFs, the entire case record will be transferred with a resident. (Also see Chapter 3.9.)

5.8.4 Retention

The IPAS agency will retain legible copies of all completed forms and related documents for a period of at least three (3) years from the last date of case action. The beginning date of the period of retention will be computed as follows:

a) for all Medicaid recipients, applicants or will-apply, denials, and marginal cases: the date of authorized OMPP signature on the PAS 4B;
b) for all PASRR related cases: the date of authorized State PASRR Program Unit signature on the PAS 4B;
c) for all IPAS-only, non-PASRR private-pay applicants, the date of signature on the PAS 4B form by the authorized IPAS agency.

If a reconsideration or appeal request is processed, the most recent decision date will be the beginning date of the retention period.

The IPAS agency will make case documents available to OMPP, the State PASRR Unit, the State Hearings and Appeals Section, and state or federal surveyors or auditors upon request and for audit purposes.

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PAS

Chapter 6

APPEALS; IPAS PENALTY; AND CLASS A INFRACTION

6.1 APPEALS, RECONSIDERATIONS, AND JUDICIAL REVIEW

An individual has the right to appeal and request a fair hearing when he/she disagrees with an adverse IPAS determination.

6.1.1 RECONSIDERATION

When there is additional documentation not previously submitted which is pertinent to the reason for denial, the individual may request a "reconsideration." When appropriate, a reconsideration request can avoid the more lengthy, formal appeal process.

The reconsideration process is an informal process designed to provide a quick review of an adverse determination. Reconsideration is only appropriate when pertinent case documentation is available which was NOT submitted for the original determination.

6.1.1.1 Reconsideration Request

OMPP or the State PASRR Unit makes all IPAS or PASRR denial determinations. Reconsiderations will be:

a) requested through the IPAS agency which processed the IPAS case;
b) made as soon as the additional documentation is identified, but no later than within thirty (30) days of the effective date of the determination;
c) submitted by the individual, legal representative, NF, and/or attending physician acting on behalf of the individual.

Reconsideration does not replace the appeals process. An individual requesting a reconsideration will be advised to request an appeal at the same time.

a) If the reconsideration upholds the original adverse finding, the appeal will proceed.
b) If the reconsideration reverses the original adverse finding, OMPP or the State PASRR Unit will advise the Hearing and Appeals Section to cancel the appeal request.

6.1.1.2 Process

Upon receipt of a request for reconsideration and the new documentation, the IPAS agency will:

a) clearly mark each piece of new documentation as such;
b) add any appropriate comments and recommendations, clearly marked;
c) place the new documentation on top of a copy of the original case packet;
d) clearly mark the top of the entire case packet as a "Request for IPAS Determination Reconsideration;" and
e) resubmit it to OMPP or the State PASRR Unit, as appropriate.

The final determination on reconsideration requests rests with the OMPP or State PASRR Unit. Following review and determination, the appropriate reviewing entity will:

a) reissue the original PAS 4B determination form, keeping the original date of issue;
b) clearly mark it as a " RECONSIDERATION DETERMINATION;" and
c) distribute the case packet with the new determination in the same manner as the original case packet.

6.1.2 APPEAL

An individual who disagrees with the final IPAS determination may appeal the decision. Brief instructions on the process to request an appeal are on the front of the PAS 4B final determination form with more detailed information on the back of the form or on an attached page.

6.1.2.1 Appeal Request

To request an appeal, the individual or representative will send a signed letter to the Hearings and Appeals Unit. (Address on PAS 4B form. Contact the IPAS agency for additional information or assistance.)

The letter needs to contain:

a) the individual's address and a telephone number where the individual can be reached; and
b) whenever possible, a copy of the final determination form attached to the letter, or a statement of the action being appealed. The individual's responsible party may assist in making the appeal request.

Hearings and Appeals will send a notice of the date, time, and place for the hearing to the individual, the IPAS agency, and OMPP or the State PASRR Unit. At or prior to the hearing, the individual:

a) will have the right to examine the entire contents of the case record at the IPAS agency;
b) may represent him/herself or authorize a representative such as an attorney, relative, friend, or other spokesman to do so;
c) will have full opportunity to bring witnesses, establish all pertinent facts and circumstances, advance any arguments without interference, and question or refute any testimony or evidence presented.

6.1.2.2 Process

Hearings and Appeals will notify:

a) the appropriate IPAS agency when an appeal has been filed and a hearing has been scheduled on an IPAS case in its area; and
b) OMPP or the State PASRR Unit, as appropriate.

The IPAS agency will prepare two (2) sets of copies of the appellant's case file for submission to the hearing officer and the appellant (or his or her designated representative).

OMPP or the State PASRR Unit will prepare written testimony concerning the basis of its final determination.

This testimony will be provided to the local Medicaid caseworker or DFC designated representative to present at the hearing on behalf of the State. An IPAS agency may be authorized by OMPP or the State PASRR Unit to present information or testimony at a hearing. As an agent of the State for the IPAS and/or PASRR programs, the IPAS agency representative will support the State authority's finding.

An IPAS agency representative may attend a hearing at the request of an individual to represent him or her when the State IPAS or PASRR determination authority has overturned an IPAS agency recommendation of approval. The IPAS agency representative will make it clear that he or she is representing the individual, not the State authority, and that any information or testimony given is made in that capacity.

Following the hearing, the hearing officer will render a finding and written notification will be sent to the individual, the State entity, and other involved entities.

6.1.3 ADMINISTRATIVE REVIEW

If either party is in disagreement with the appeal decision, it can request administrative review by FSSA. The determination of the administrative law judge (ALJ) on the appeal is reviewed by the Secretary of FSSA (or an Agency designated representative) prior to submission to judicial review.

6.1.4 JUDICIAL REVIEW.

If either party disagrees with the decision after exhausting all administrative remedies, it may obtain judicial review. Information on how to obtain judicial review will be provided to the individual as part of the appeal determination notice.

6.2 IPAS PENALTY

Individuals incur a penalty if admitted to or remain in a NF after:

a) refusal to participate in the IPAS program; or
b) determination that NF placement is not appropriate.

NOTE: For PASRR, IPAS is a part of PAS/PASRR. It is a violation of the NF's Medicaid participation agreement to admit or retain persons requiring PASRR Level II assessment without IPAS and PASRR compliance, regardless of the IPAS penalty provision

6.2.1 Definition

The IPAS penalty consists of ineligibility for Medicaid reimbursement of NF per diem as a covered Medicaid service. It does not render the individual ineligible for Medicaid or other Medicaid covered services.

NOTE: Under Medicaid federal regulations, Medicaid reimbursement can be made only if the individual minimally meets the Medicaid criteria of need for NF services in effect at the time of admission or during the period for which reimbursement is requested, regardless of designee authorization. Appropriately applied designee authorization will only assure that the IPAS penalty is not applied for an individual who meets Medicaid eligibility requirements. It does not guarantee Medicaid reimbursement.

6.2.1.1 Failure to Notify Applicant

As soon as it is determined that the NF failed to provide notice of IPAS participation requirements, an individual:

a) must be notified of IPAS requirements; and
b) given the opportunity to complete the Application, choosing whether to participate in IPAS.

(If PASRR Level II is needed, the individual cannot refuse and be admitted to or remain in a Medicaid certified NF.)

NOTE: No time limit is specified in the governing IPAS law or rule for this notification requirement. 460 IAC 1-1-5(k) provides that an individual who was not notified of the requirement for IPAS and who is in a NF may be prescreened after receiving notification of the requirement.

An individual who was NOT notified of the IPAS program requirements by the NF and was admitted will incur no IPAS penalty unless, after receiving notification of the requirement, the individual:

a) Refuses to participate; or
b) Participates and is found not appropriate for NF placement, but remains in the NF. The IPAS agency will document the circumstances of an individual who was admitted to the NF without the appropriate IPAS notification, specifying applicable dates.

In this case, the IPAS penalty will be incurred beginning with the date of notification that IPAS is required rather than the date of NF admission.

The IPAS agency will clearly document the circumstances affecting imposition of the IPAS penalty in the case record and on the PAS 4A form and/or the PAS 4B form.

NOTE: Medicaid federal regulations, however, link reimbursement with the timely receipt of necessary documentation to determine eligibility. Substantial delay of such documentation may jeopardize Medicaid reimbursement for all or a portion of the time for which reimbursement is

sought, regardless of other authorization(s). [42 CFR 456.260 and 261; 42 CFR 456.360 and 362]

A NF THAT FAILS TO APPROPRIATELY NOTIFY INDIVIDUALS OF IPAS REQUIREMENTS COMMITS A CLASS A INFRACTION. (See Chapter 6.3.)

- At the time it is determined that an individual was not notified, the IPAS notification will be provided. If the individual agrees to participate in IPAS, the assessment will be completed and a determination rendered as soon as possible, but no later than twenty-five (25) days from application.

- If the individual refuses to participate, he or she will incur the penalty beginning with the date of notification that IPAS is required. The individual will incur no penalty for the period during which he or she was not notified.

6.2.1.2 Duration

The IPAS penalty lasts for up to one (1) year from the date of admission. In the IPAS law, the time is broken into two (2) levels which were linked to the Medicaid reimbursement system in effect at the time the law was written for:

a) intermediate care facility (ICF) (470 IAC 5-3-3);and
b) skilled nursing facility care (SNF) (470 IAC 5-3-2).

NOTE: An individual residing in the NF for more than one (1) year after incurring the penalty may request Medicaid reimbursement for NF per diem. However, the individual must still meet all Medicaid eligibility requirements.

"ICF:" IC 12-10-12-33 imposes a one (1) year period of ineligibility for Medicaid per diem reimbursement from the date of the individual's admission to the NF for an individual who:

a) Does not participate in IPAS; or
b) Participates in IPAS, is notified that placement in a NF is not appropriate, but enters or remains in the NF regardless of the IPAS finding.

"SNF:" IC 12-10-12-34 also imposes a period of ineligibility for Medicaid per diem for SNF care which differs from ICF in that it may be imposed for less than the full year.

The SNF penalty applies to an individual who:

a) refuses to participate in IPAS; or
b) participates in IPAS and is notified that the individual's placement is not appropriate.

For an individual in need of SNF care:

a) the penalty will continue only until the individual receives a determination that placement in SNF level of care is appropriate; but
b) in no case will it last more than one (1) year from the date of admission.

If the IPAS finding is that ICF care is the appropriate level, the provisions of the ICF penalty will continue to apply.

NOTE: OMPP has clarified that, since compliance with IPAS is required in Indiana for NF per diem coverage under Medicaid, Medicaid reimbursement for NF per diem will be withheld for an individual who would otherwise meet "SNF" need for NF services until the individual meets IPAS requirements.

6.2.1.3 Relief of the "SNF" Penalty Period

If an individual :

a) requires Medicaid NF per diem reimbursement before the expiration of the one (1) year penalty period; and
b) is in need of the level of NF services reimbursable under SNF;

the NF must contact the IPAS agency for directions as soon as possible. The IPAS agency will process an IPAS assessment, clearly noting the circumstances in the IPAS record.

The IPAS penalty:

a) will be lifted on the date that the individual receives an IPAS determination on PAS Form 4B that SNF placement is appropriate;
b) applicable time limits of the IPAS penalty period will be specified on the PAS Form 4B; and
c) the penalty period will be computed to include the period authorized under designee-authorization for temporary stay, except that the penalty will not be "imposed" for the designee-authorized time.

6.2.1.4 Other Provisions

a) A person admitted to a NF on appropriate designee authorization will not incur the penalty for the authorized period if, regardless of when the determination is made:
   1) placement in the NF is determined to be appropriate under IPAS; or
   2) the individual is discharged from the NF within fourteen (14) days after receipt of the decision that placement in the NF is inappropriate. This period of time allows for NF discharge planning.
b) The effective time of the penalty will be computed to include the designee authorized period plus the fourteen (14) days, but the penalty will not be imposed for the period under designee authorization or discharge planning.
c) The penalty will not be levied against an individual who is eligible for and requires Medicaid Waivered services, but chooses to go into a NF.
d) The incurred duration period of the penalty continues to be in effect even when an individual leaves the NF during the penalty period and is admitted again before the penalty period has expired.

NOTE: Even though an individual is still under a one-year penalty when he or she seeks readmission to a NF, the NF must follow all IPAS requirements anew. The NF:

a) will again notify the individual of IPAS requirements;
b) take a new Application; and
c) transmit it to the IPAS agency with a full explanation.

The IPAS agency will issue another PAS 4B explaining the status of the new IPAS application.

6.2.2 IPAS Agency Role

The IPAS agency will:

a) receive all Applications (including agreements and refusals to participate);
b) make appropriate judgments concerning their status;
c) record and track information;
d) process the Application; and
e) when an IPAS penalty has been incurred, issue notice of the penalty on PAS 4B.

6.2.2.1 Tracking Penalties

The IPAS agency is responsible:

a) for keeping a log of individuals who are under IPAS penalty;
b) in order to respond to requests from OMPP; and/or
c) to assure future assessments are not completed for individuals under IPAS penalty.

For individuals who are currently under IPAS penalty, the IPAS assessment will only be completed after:

a) the penalty has been discharged through an appeal;
b) it is determined that the penalty was incorrectly imposed; or
c) there is a claim that the individual needs "SNF" level of NF services.

6.2.2.2 PAS 4B Issuance

When it is determined that the IPAS penalty has been incurred, the local IPAS agency will issue a PAS 4B form which notifies the individual of the penalty and its consequences. For statewide consistency and accuracy, the following statement will be entered on the PAS 4B:

> "Your Long-Term Care Services Application (IPAS Application) dated _____, which is checked that you do not agree to participate in Indiana's PreAdmission Screening (IPAS) program, has been received by this office. This notice is to advise you that admission to any Indiana licensed nursing facility without participation in IPAS carries a penalty of non-payment by Medicaid of per diem costs for up to one (1) year. The penalty period may be less if you require skilled nursing care. If you require skilled level of nursing care during this period and wish to participate in IPAS, or if you have any questions concerning this notice, please contact (local IPAS agency information) immediately."

When the PAS 4B is issued by OMPP or the State PASRR Unit, substitute the following sentence for the first sentence:

> "There has been an IPAS and/or PASRR determination that your placement in a NF is inappropriate."

Additional information or explanation may be added to the PAS 4B form.

6.2.2.3 Penalty Imposition

The IPAS penalty is incurred as specified in Chapter 6.2. It is imposed when an individual who has incurred the penalty applies for Medicaid NF per diem reimbursement during the penalty time period. OMPP will require a copy of the Form PAS 4B when the NF requests Medicaid per diem reimbursement to confirm the status of the individual.

NOTE: Every individual admitted to an Indiana licensed NF will have received a PAS 4 or, for Medicaid Waiver recipients, HCBS 4 issued either by the local IPAS agency, OMPP, or the State PASRR Unit.

6.2.3 Medicaid Reimbursement

After the expiration or termination the one (1) year penalty period, an individual may be eligible to receive Medicaid NF per diem reimbursement. The individual will need to meet all other Medicaid eligibility requirements.

NOTE: For instructions concerning an individual who was never notified of the IPAS requirement, see Chapter 6.2.

The NF will submit to OMPP:

a) a current Form 450B (Sections I-III, Physician's Certification of Need for Long-Term Care Services):
b) an explanation giving the specific NF admission date to show that the penalty period has expired;
c) a copy of the original PAS 4B indicating that the IPAS penalty applies;
d) if applicable for IPAS penalty relief due to SNF need, a copy of the PAS 4B which shows that the individual qualifies for relief from the IPAS penalty due to need for SNF level of care; and
e) any other documentation required by OMPP to document that the individual meets Medicaid requirements.

6.2.4 Waiver of the IPAS Penalty

Under specific conditions, an individual may request a waiver of the IPAS penalty so that he or she can be admitted to the NF before the IPAS determination is rendered.

a) Only an individual who is being assessed "From Home" may request the IPAS Penalty Waiver.

b) The Waiver of the IPAS penalty only applies if the IPAS assessment and determination are not completed within the twenty-five (25) day time limit.
c) If granted, the waiver of the IPAS penalty will only allow the individual to be admitted to the NF prior to the IPAS determination, without incurring the IPAS penalty for the period of time spent in the NF until the IPAS determination is rendered. (See Conditions for a Waiver, Chapter 6.2.4.1.)

Without the waiver of the IPAS penalty, admission to the NF before final IPAS approval may only be done under appropriate designee authorization. Admission without approval nullifies the "waiver" provision and incurs the IPAS penalty.

NOTE: Only the IPAS penalty is waived. All other requirements for NF admission and/or Medicaid reimbursement remain the same. IPAS assessment and determination will be completed as required, regardless of the waiver of the IPAS penalty.

The IPAS penalty Waiver does not apply to PASRR Level II cases.

6.2.4.1 Conditions for a Waiver

The IPAS agency will immediately investigate and document a request for a waiver of the penalty. When requested by the OMPP, the IPAS agency will provide sufficient information to ascertain whether conditions for the waiver request are met.

The following conditions will be investigated and documented by the local IPAS agency:
a) the applicant made an appropriate IPAS application;
b) the assessment was subject to the twenty-five (25) day "From Home" provision;
c) the applicant or his or her representative applied in writing in a timely manner for the waiver to the local IPAS agency;
d) the application for the waiver was made promptly following the expiration of the 25-day processing time period;
e) the NF, and hospital if applicable, cooperated in the IPAS assessment promptly;
f) the applicant, the applicant's physician, the applicant's custodian, and other necessary entities cooperated in the IPAS assessment in a timely manner; and
g) the IPAS determination was not rendered within the 25-day limit.

If all conditions above are met, the individual qualifies for the waiver of the IPAS penalty and will not be penalized for admission to the NF without IPAS prior approval or designee authorization.

6.2.4.2 Processing a Waiver Request

The request is made to the local IPAS agency. The IPAS agency will immediately compile the documentation for the request. The documentation of the criteria in Chapter 6.4.2.1 will be sent in a timely manner to the entity responsible for the final IPAS determination: OMPP or the IPAS agency.

As soon as the investigation is complete, the IPAS agency will immediately forward the request and the investigation results to OMPP, which will review all documentation and, either:
a) issue the IPAS case determination; or
b) if all conditions are met, issue a waiver of the IPAS penalty.

OMPP will::
a) render the decision within two (2) working days following receipt of the waiver request;
b) if given verbally, immediately issue the decision in writing;
c) maintain written documentation on the waiver decision for a period of not less than three (3) years; and
d) send a copy of the decision to the applicant or his or her representative, the NF, and the appropriate IPAS agency.

6.3 CLASS A INFRACTION

Indiana Code (IC 12-10-12) establishes specific functions to be performed by NFs under burden of committing a "Class A infraction." IC 34-4-32-4 establishes that a judgment of up to ten thousand dollars ($10,000) may be entered for a violation constituting a Class A infraction.

6.3.1 NF Notification Requirements

IC 12-10-12-6 specifies that a NF will provide notification of the IPAS requirements for NF admission to an individual or the individual's parent or guardian. IC 12-10-12-9 states that the "notification" required will be in writing on standardized forms prepared by DDARS and provided to NFs. The applicable forms are the "Long-Term Care Services Application" form and the IPAS Information Sheet.

The required notification (IPAS Information Sheet) will apprise the applicant that the:

a) applicant is required under State law to apply to the local IPAS agency for participation in Indiana's Pre-Admission Screening (IPAS) program;
b) applicant's failure to participate in IPAS could result in the applicant's ineligibility for Medicaid reimbursement for NF per diem in any NF for not more than one (1) year;
c) IPAS program consists of an assessment of the applicant's need for care in a NF made by a team of individuals familiar with the needs of individuals seeking admission to a NF.

The notification will be signed prior to admission by the applicant or the applicant's designated representative, if the applicant is not competent.

If the applicant is admitted, the NF will:

a) retain one (1) signed copy of the notification for one (1) year; and
b) deliver the signed application to the local IPAS agency.

460 IAC 1-1-6(c) requires that the NF forward a copy to the IPAS agency within five (5) working days from the date of signature or, if the individual is admitted to the NF, from the date of admission. 460 IAC 1-1-6(d) makes the NF responsible for providing verification that:

a) the application for IPAS was made prior to admission;
b) an applicant admitted prior to final determination had designee authorization; and
c) the application and other designated documentation were forwarded to the IPAS agency within five (5) working days from the date of designee authorization.

Failure of an administrator, or the members designated to the governing body of the NF to ensure compliance with IPAS notice requirements, constitutes a Class A infraction.

Indiana Administrative Code, 460 IAC 1-1-6(d), clarifies that the NF is responsible for providing verification that:

a) the application for IPAS was made prior to admission;
b) an individual admitted prior to the IPAS determination had appropriate designee authorization for admission, as required; and
c) the copy of the application and other designated documentation were promptly forwarded to the IPAS agency.

6.3.2 Applicant Never Notified

IPAS rules specify that an individual who was not notified of the requirement for IPAS assessment and who is in a NF may be prescreened after receiving notification of the requirement. There is no time limit to this requirement. (See Chapter 6.2.1.1.)

6.3.3 Refusal to Sign Application

Also see Chapter 2.6.3.

The applicant or the applicant's designated representative may refuse to sign the IPAS Application after the NF gives notice. To document that notification was given, the NF's administrator or

designee will clearly note the circumstances on the IPAS Application form, sign and date it. The applicant's name, address, and necessary identifying information need to be included on the IPAS Application form.

The NF will promptly send the unsigned, annotated IPAS Application form to the local IPAS agency in the same manner as if it had been signed. The IPAS agency will process it as a "refusal to participate." If the individual is admitted to the NF, a notation must be made on the PAS 4B regarding the IPAS penalty.

The IPAS agency must also make the certification of need for Level II at the bottom of the Level I. If the individual needs Level II, a Medicaid-certified NF will be in violation of its Medicaid certification agreement to admit the individual or allow him/her to remain.

NOTE: An IPAS Application will be submitted to the local IPAS agency for every individual admitted to a NF. This includes applications for "agree to participate," "refuse to participate," and "refuse to sign." The IPAS agency will issue a PAS 4B form for every Application form received.

6.3.4 IPAS Agency Report

460 IAC 1-1-7(14) requires the IPAS agency:

a) to report Class A Infractions to the prosecuting attorney serving the county of the NF (460 IAC 1-1-6);
b) regardless of the prosecuting attorney's action on the report.

All such reports become a matter of public record and a copy of the report will become part of the case record.

6.3.4.1 Determination of Infraction

The IPAS agency will base the determination of a Class A infraction on requirements in 6.3.1, above.

6.3.4.2 Progressive Action

Occasionally, circumstances beyond the NF's control may dictate a more moderate approach to the reporting requirement. The IPAS agency will judge whether the following progressive steps are appropriate to address the report of a Class A infraction for a particular NF.

NOTE: This procedure can not be used with NFs that have a demonstrated history of non-compliance with IPAS requirements. NFs which frequently ignore or refuse to comply with laws and regulations will be reported to OMPP for further action. A copy will also be sent to the County Prosecuting Attorney. (See Chapter 6.3.4.3 on Tracking.)

a) On the first violation, the IPAS agency may give the NF a verbal warning including a stipulation that the NF will secure training on the IPAS program requirements from the local IPAS agency. It is the responsibility of the NF to assure that training is provided to appropriate NF staff.

   The IPAS agency will document in its records that the verbal warning was given, including the reason for the use of the progressive reporting procedure.

b) The second violation requires a written warning from the IPAS agency to the NF administrator with courtesy copies to the owner/corporate level staff. The warning notice will document:
   1) the prior verbal warning;
   2) whether the required IPAS training was secured with details of the training; and
   3) a requirement for the NF to obtain additional IPAS training.
c) Further violations require a written report by the IPAS agency, on standardized forms, to the county prosecuting attorney. Specific reference to or copies of the warnings from the first two steps will be included or attached to report.

This progressive system will only be used when there is demonstrable evidence that the NF had a reasonable excuse for the non-compliance.

Whatever action is pursued, the IPAS agency will record in its files the nature of the action and the reason(s) for the selection of a particular approach for audit and accountability purposes. A copy of the correspondence will be placed in the individual's case record.

6.3.4.3 Report Format

To maintain consistency, all IPAS agencies will utilize the State designated format, on the agency's letterhead, to report the Class A infraction. This format has been reviewed and approved by the FSSA Office of General Counsel to assure that it meets IPAS requirements. (See Appendix Q.)

The report will specify the NF administrator, or the members designated to the NF governing body, as the individual held responsible for ensuring compliance with notice requirements. When applicable, the report will be carbon copied to the NF's owners, corporate office, board, ISDOH, etc.

6.3.4.3 Documentation, Notification, and Tracking

In order to validate timely submission of the Application to the IPAS agency, the IPAS agency will stamp the date received on each Application form, Level I, and other pertinent documents.

Reports of Class A infractions will be documented in the individual's case record. The IPAS agency will also track the occurrence of Class A infractions by NFs, including the type of action taken by the IPAS agency.

If mail problems or other processing procedures are consistently being claimed as the reason Applications are missing or not received, the NF should make a follow-up phone call to the IPAS agency a few days after mailing to assure that the Application is received at the IPAS agency office.

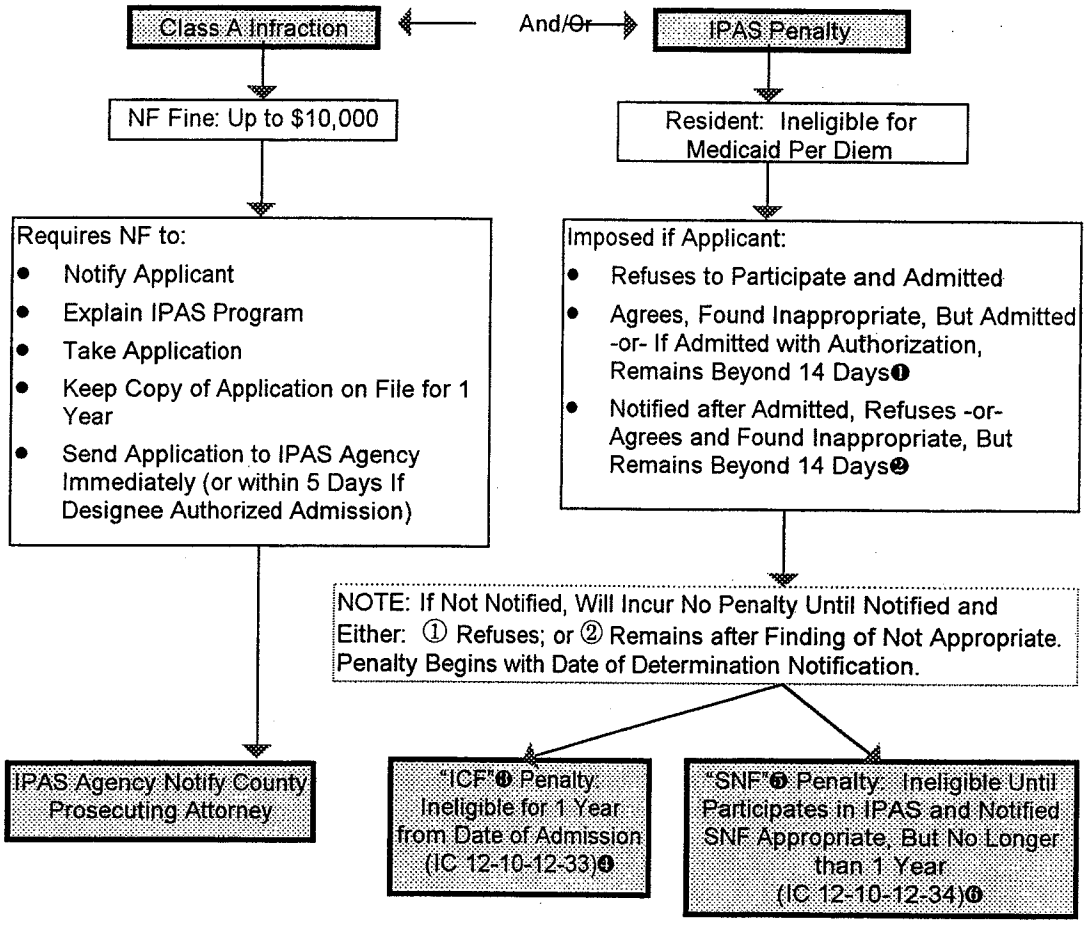
A courtesy copy of the report of a "Class A infraction" will be sent to:

a) the NF administrator, the owner and/or corporate office, the designated NF governing body: and
b) the applicant or designated representative, as indicated.

Persistent problems of non-compliance will also be referred to the Indiana Department of Health, Division of Long-Term Care, the NF Ombudsman, and/or, if appropriate, APS.

Continuous and persistent Class A Infractions by a NF should be reported to OMPP and the State IPAS program.

COMPARISON OF CLASS A INFRACTION AND IPAS PENALTY
Chapter 6



❶*460 IAC 1-1-14(b): Allows 14 days for NF discharge planning for person temporarily admitted to NF under designee authorization who placement is determined to be inappropriate.*

❷*An individual not notified of the IPAS requirement will incur no penalty, unless the individual refuses to be screened after notification or is found to be inappropriate for NF services, in which case the individual will incur the penalty beginning with the date of notification that IPAS is required. [460 IAC 1-1-14(d)]*

❸*Refers to intermediate (I) care in a NF.*

❹*Admission: A person is admitted to a NF as soon as that individual is physically present in the NF, unless the admission is designee-approved. A person approved by a designee is considered admitted twenty-four (24) hours after entering the NF. (460 IAC 1-1-2) The time of the IPAS penalty will be computed to include the period of authorization , but will not be imposed for such designee authorized time. [460 IAC 1-1—14(c)]*

❺*Refers to skilled (S) care in a NF.*

❻*IC 12-10-12-34 allows an individual needing the level of NF services previously designated SNF, who refused IPAS at NF admission, to decide to agree and be IPAS assessed. If skilled NF placement is determined to be appropriate, the remainder of the IPAS penalty will be lifted effective when the individual receives the determination on the PAS 4B form. In no case will the IPAS penalty last more than one (1) year from the date of NF admission. [460 IAC 1-1-14(c)]*

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Chapter 7

MEDICAID WAIVER AND CASE MANAGEMENT

7.1 MEDICAID WAIVER SERVICES

The Medicaid Waiver Services program applies to IPAS in that: #TBI,

a) applicants for Indiana's "Aged and Disabled" (A&D) and "Medically Fragile Children" (MFC) Waivers must participate in Indiana's IPAS program; and
b) eligibility for Medicaid Waiver services should be considered by the IPAS assessor when constructing the IPAS and/or PASRR plan of care.

Medicaid Waiver Services are those specific in-home and community-based services available for Medicaid reimbursement only under a federally approved "waiver." The parameters of each Medicaid Waiver service are contingent on the limits requested by each state and approved by HCFA. IPAS requirements must be met by individuals covered under these two (2) Waivers.

7.1.1 General Information

The A&D and MFC Waivers provide services to aged adults and persons with disabilities who would otherwise require the level of services provided in a NF.

7.1.1.1 Eligibility

In general, Medicaid A&D and MFC Waiver eligibility requirements direct that the individual must be:

(a) eligible for Medicaid;
(b) at risk of institutionalization (in the absence of Medicaid Waiver services);
(c) screened under IPAS;
(d) meet need for NF level of services criteria (Level of Care); and
(e) be given the choice to utilize the Medicaid Waiver services or be admitted to a NF.

The criterion of "at risk of institutionalization" means that:

a) the individual must, but for the availability of Medicaid Waiver service(s), meet all requirements of need for NF level of services; and
b) if qualified, must be given a choice to accept the Medicaid Waiver service(s); or
c) be admitted to a NF.

All requirements for NF placement must be met and approval for NF admission rendered PRIOR to the offer of Medicaid Waiver services.

Each Medicaid Waiver, depending on the type of Waiver being considered, may impose other restrictions.

7.1.1.2 PASRR Requirements

As soon as a recipient of A&D or MFC Medicaid Waiver services chooses placement in a NF, the IPAS Agency will:

a) determine whether PASRR Level II assessment is required; and
b) if Level II is needed, make referrals for Level II directly to the CMHC or D&E Team;
c) send the letter of Level II referral to the applicant and/or health representative, Waiver Services case manager, and NF; and
d) regardless of need for Level II, send a copy of the IPAS agency certified Level I to the NF.

See Chapter 15 for instructions for processing Level II assessments for Medicaid Waiver recipients.

7.1.2 NF Admission of a Medicaid Waiver Services Recipient

The "freedom of choice" to enter a NF is applicable:

a) throughout the time that an individual meets the Waiver requirements; and
b) is an active recipient of the A&D and MFC Waivers.

7.1.2.1 NF Action

When a NF receives a request for admission from a Medicaid Waiver recipient, the NF must:
a) immediately notify the IPAS agency and/or the Waiver Case Manager of the request;
b) PRIOR to admission or immediately following designee approved admission.

As always, the NF must NOT admit or retain any individual:
a) for whom it cannot provide the level of services needed; or
b) who requires PASRR Level II, but has not been assessed and approved for placement.

A NF must assure that, for every individual it admits, it has a copy on the chart of the:
a) PAS Form 4B; or
b) for Medicaid Waiver recipients, the HCBS Form 3: Statement for Freedom of Choice (Appendix S) or the HCBS Form 7: Transmittal for Medicaid Level of Care Eligibility (Appendix R).

7.1.2.2 Medicaid Waiver Recipient/Care Manager Action

A Medicaid Waiver recipient must:
a) report any change in circumstances which affects eligibility for Waiver services; and
b) choosing NF placement is a reportable change.
The individual or the individual's legal representative must immediately contact the Medicaid Waiver care manager.

It is the responsibility of the Medicaid Case Manager to:
a) assure that the recipient understands the need to report such changes PRIOR to NF admission, whenever possible or immediately following NF admission; and
b) report or assure that the selection of NF admission is reported to the appropriate IPAS agency for a determination of need for Level II assessment.

7.1.2.3 Transmittal of Case Record to NF

Each NF is required to:
a) maintain certain case documentation on file; and
b) utilize the assessment and needs findings in its care planning.
The Waiver Care Manager must provide the NF with the necessary IPAS/PASRR documentation and case record at the time of admission.

Applicable documentation which the Waiver Case Manager must provide and which the NF must maintain on the NF active record and use for the Care Plan corresponds to the IPAS case packet. It includes, at a minimum, the following forms:
a) Application for Long-Term Care Services;
b) PASRR Level I;
c) Form 450B, Sections I-III, Physician Certification of Need for Long-Term Care Services;
d) (For MR/DD, include Form 450B, Section VI);
e) PASRR Level II Assessment, when applicable;
f) Long-Term Care Services Eligibility Screen;
g) Form HCBS 3, Waiver Freedom of Choice, showing choice of NF or HCBS Form 7, Transmittal for Medicaid Level of Care Eligibility.

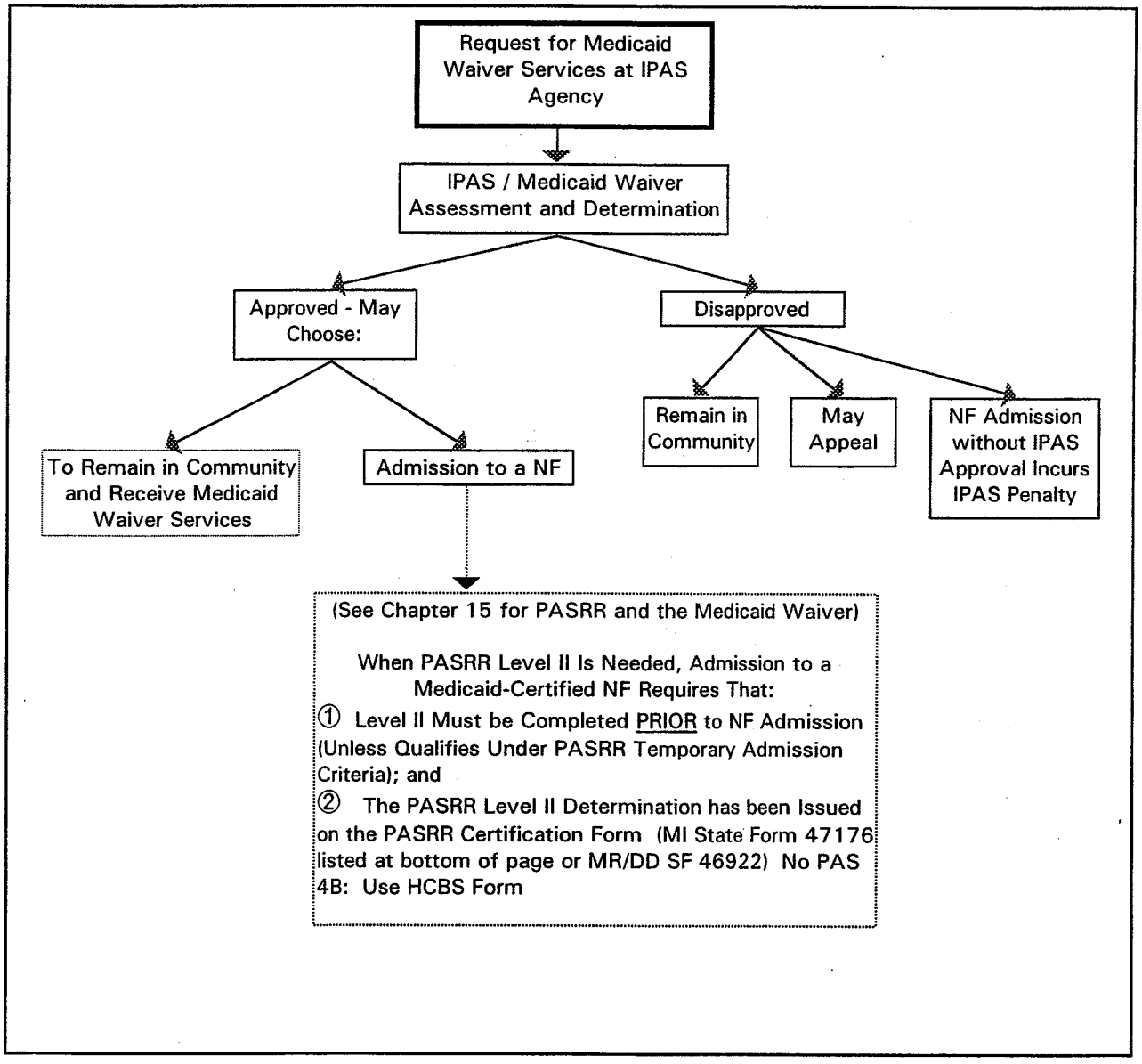
7.1.3 NF Request for Medicaid Reimbursement

A NF submits its request for Medicaid reimbursement of NF per diem to OMPP following the usual procedures.

There will not be a PAS Form 4B for an individual who, immediately prior to NF admission, was a Waiver Services recipient. Either the Form HCBS 3 or HCBS 7 will replace the PAS 4B when the NF requests reimbursement for NF per diem from OMPP.

To assure that OMPP can expeditiously process the request for NF per diem approval, documentation submitted to OMPP needs:
a) to be clearly marked by the NF as "Medicaid Waiver Services;"
b) in the top margin of the Form 450B;
to alert OMPP to the status of the request.

IPAS AND THE MEDICAID WAIVER PROCESS
Chapter 7



7.2 CASE MANAGEMENT REFERRAL

For all denied cases, the IPAS assessor or coordinator must:
a) make a bona fide referral of the individual to available case management service(s);
b) provide information on the assessment and necessary service needs identified through the IPAS assessment and care-planning.

This information will avoid duplication of effort and expedite processing by the case management system receiving the referral.

When no case management service is available or the individual does not meet requirements, the IPAS coordinator should assure that the applicant or his/her representative receives all service information which may have resulted from the IPAS assessment and care plan. This information should be detailed enough that the individual or interested representative will be able to pursue identified services or options.

Chapters 8 and 9 reserved for future use.

Information contained herein is CONFIDENTIAL according to IC 16-14-1.6-8.

LEVEL II: PASRR / MI MENTAL HEALTH ASSESSMENT

State Form 47185 (R4 / 7-98) / BAIS 0036

☐ PAS (PreAdmission Screening) ☐ New Mental Health Assessment ☐ Updated PAS	Give date of IPAS agency initial referral:	Give date returned to IPAS agency:	Send completed forms to: "LOCAL IPAS AGENCY"
☐ RR (Resident Review): ☐ Yearly RR ☐ Significant - Change RR	Prior Level II done: ☐ Yes ☐ No ☐ Unknown If "Yes" complete for most-recent: (1) Check: ☐ PAS ☐ PAS Update ☐ Yearly RR ☐ Significant-Change RR (2) Give date of psychiatrist signature: _____		Send completed RR Check-list with RR Case(s) to: MS21 PASRR / MI Program, Room W454, P.O. Box 7083 Indianapolis, IN 46207-7083

Name of ☐ PAS applicant or ☐ NF resident:	Birthdate (*month, day, year*):	Age:	Sex: ☐ Male ☐ Female
Location where Level II completed (*name, address, city, state, ZIP code*) (*home or include name of facility or hospital*):		If in NF, date of initial admission:	
Name and address of CMHC or hospital completing Level II: *		Date of evaluation (*mo., day, yr.*):	

* This Level II assessment was completed by an entity which is not a nursing facility and has no direct or indirect affiliation with such facility. [P.L. 101-508, Sec. 408 (b)(1-8) and 42 CFR 483.106 (e)(3)]

I. PAS location of applicant (*check all that apply*):

- ☐ At own home / residence
- ☐ In hospital: ☐ Acute Care ☐ Non-Acute Care ☐ Psychiatric ☐ Non-Psychiatric
- ☐ In NF from home: ☐ APS ☐ Respite Stay
- ☐ Continued stay in NF beyond exempted hospital discharge
- ☐ Other: _____

II. Significant - Change RR purpose (*check all that apply*):

- ☐ Required Level II not completed
- ☐ Change in mental status WITHOUT hospitalization
- ☐ Change in mental status WITH hospitalization
  - ☐ In hospital (*No prior Level II*)
  - ☐ In NF (*Readmitted on basis of current Level II*)
- ☐ Other: _____

III. "Missed Level II": (*check one*)

☐ PAS ☐ Yearly RR ☐ Significant-Change RR

Security number	Medicare number	Medicaid number

I. DRUG HISTORY

The PASRR / MI assessment process must provide a comprehensive drug history, including current and immediate past use of medications with particular attention to use of medications that could mask symptoms or mimic mental illness. [42 CFR 483.134 b(2)] The psychiatrist should review the medications for appropriateness and medication interaction.

LIST ALL CURRENT MEDICATIONS	DOSAGE / FREQUENCY	START DATE	REASON FOR PSYCHOTROPIC MEDICATIONS (*If Unknown, Explain*)

OPTION: Please see attached medication sheet. ☐ Yes ☐ No

SIGNIFICANT - CHANGE RR AND UPDATES ONLY: Reviewed current Level II and no significant changes: ☐ Yes ☐ No

INAPPROPRIATE REFERRAL (*Identified after assessment begun: Stop and complete Inappropriate Referral form.*)

PAST TWELVE MONTHS (*Major Psychotropic Drugs*)	DOSAGE / FREQUENCY	START / STOP DATES	REASON / PURPOSE FOR PSYCHOTROPIC MEDICATIONS

RR AND UPDATES ONLY: Medications reviewed, but no change since last Level II. ☐ Yes ☐ No

Name of applicant	Social Security number	Date of birth

II. PSYCHOSOCIAL REPORT

The PASARR / MI process must include a psychosocial evaluation of the person, including current living arrangements and medical and support systems. CFR 483.134 (b) (3)]

CURRENT LIVING ARRANGEMENT (*Brief description*) What has been this person's residence for the last several years? How long has this person lived in the nursing facility? What is this person's stated preference of living arrangement? Is it feasible? Explain. Add any other pertinent details deemed appropriate.

SUPPORT SYSTEMS (*Family, friendships, church, associations, etc.*) What emotional support does this person have? How extensive is the support system outside the NF? Where do they live? Who actively supports the person? Explain. For PAS cases, have you contacted the persons listed? Is there a legal guardian? Is the guardianship full or limited? Include names and addresses, if available.

MEDICAL SYSTEMS Identify this person's attending physician. (*Other pertinent medical professionals may be entered, as deemed necessary.*)

If the psychological evaluation is not conducted by a social worker, than a social worker's review and concurrence with pages 1 and 2 above is required and must be documented by a co-signature below. [42CFR 483.134 (c)] Specify social worker's credentials: LSW, LCSW, BSW, and / or MSW.

Signature of evaluator	Professional credentials	Date (*month, day, year*)	Telephone number
Co-signature (*if needed*)	Professional credentials	Date (*month, day, year*)	Telephone number

III. PSYCHIATRIC HISTORY AND EVALUATION

The PASARR / MI process must be a comprehensive assessment. At a minimum, this assessment must address the following areas: complete psychiatric history for the past 24 months, including all hospitalizations and / or out-patient episodes; evaluation of intellectual functioning, memory functioning, and orientation; description of current attitudes and overt behavior; affect; suicidal or homicidal ideation; paranoia; and degree of reality testing (*presence and content of delusions*) and hallucinations. (42 CFR 483.134) Attach copies of all available discharge summaries dated within the past 24 months. You may summarize information from records. If unavailable, note and explain.

A. NAME OF TREATMENT LOCATION	DATE OF ADMISSION	DATE OF DISCHARGE	DIAGNOSIS (*Include current DSM code whenever possible*)	DISCHARGE SUMMARY

Is this individual currently receiving mental health services? ☐ Yes ☐ No

If "Yes", specify:

INDIANA PASRR PROGRAM
SCREEN FOR DEPRESSION
(Use to Determine If a Person Needs to be Referred for PASRR/MI Level II Assessment)

State Form 47179 (R/7-98) / BAIS 0026

See instructions on the reverse side.

SOCIAL SECURITY NUMBER	PRIVACY NOTICE
*Your Social Security number is requested in accordance with IC 4-1-8; however disclosure is not mandatory.	THIS FORM IS **CONFIDENTIAL** PER IC 4-1-8

Name of individual	Social Security number *	Date of Birth

FOR IPAS AGENCY USE ONLY

Not required for all persons with depression. Only complete the following questionnaire in situations when there is a question of whether a diagnosis or condition of "depression" is of a duration or intensity sufficient to require PASRR / MI Level II assessment. Completion of this form will help document the referral decision. When it is completed, this form must be made part of the IPAS / PASRR case record and maintained on the NF active record. Use the suggested questions included below, but the assessor is not limited to these questions.

Whether the condition of depression requires Level II assessment is determined not by the situation or terminology used, but by the depression's duration and / or level of intensity. Use of the terms "situational" or "reactive" depression are often misleading. Depression due to a general medical condition or resulting from grieving may be related to the thought of having to give up one's home and / or independent life-style ("pre-grieving") and / or may be related to the loss of a loved one or of one's physical well-being. Questions should be directed to your CMHC PASRR contact person, and the contact information, including response,recorded below. Some situations require a judgment call by the IPAS screener. This Depression Screen provides some guidance, but is not intended to be the sole determinant.

NOTE: Cases using this form, regardless of results, must be handled as a PASRR case and submitted to the State PASRR Unit for final determination.

1. The person experiences recurrent thoughts of death (*not just a fear of dying*) or suicidal thoughts (*regardless of intention to carry it out*). (*Do you have thoughts of killing yourself?*)	☐ Yes ☐ No
A "Yes" answer to #1 always requires referral for Level II as soon as possible.	
2. The person experiences a depressed mood most of the day, nearly every day. (*What is your mood today? Have you been feeling sad, blue, down, or depressed? For how long? How bad is the feeling?*)	☐ Yes ☐ No
3. The person experiences **markedly** diminished interest or pleasure in all or almost all activities most of the day, nearly every day. (*What do you normally enjoy doing? What do you still enjoy? Do you enjoy them as much as usual?*)	☐ Yes ☐ No
4. The person has experienced a **marked** change in appetite. (*Is your appetite different than usual? In what way? For how long?*)	☐ Yes ☐ No
5. The person has experienced **significant** weight loss when not dieting or **significant** weight gain in the past month. (*Have you lost weight or gained weight lately? How much? Why?*)	☐ Yes ☐ No
6. The person has experienced a **significant** change in sleeping patterns. (*Has there been a change in your sleep patterns? When did this change start? How often does it occur?*)	☐ Yes ☐ No
7. The person complains about a **significant** change in energy level. (*Do you get unusually tired or worn out? Explain*)	☐ Yes ☐ No
8. The person experiences feelings of worthlessness or **excessive or inappropriate** guilt (*not merely self-reproach or guilt about being sick*). (*How do you feel about yourself lately? Do you feel worthless or a failure? How long have you felt this way?*)	☐ Yes ☐ No
9. The person experiences a diminished ability to think or concentrate or experiences indecisiveness. (*Are you having more difficulty than usual concentrating on your activities? Making every day decisions?*)	☐ Yes ☐ No

Duration of symptoms:

☐ 30 days ☐ 60 days ☐ 90 days ☐ More than 90 days

A "Yes" response to any two (2) of Questions #2-#9 is an indication for a referral for a PASRR / MI Level II assessment.

ADDITIONAL COMMENTS / SUMMARY

DETERMINATION:

☐ Yes, PASRR / MI Level II needed. ☐ No, PASRR / MI Level II not needed. (*If No, include on PAS 4A and 4B the caveat from the back of this form.*)

Information provided by:	Relationship to applicant:

Signature and printed name of person completing protocol:	Telephone number	IPAS Agency number:	Date:

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Chapter 10

Introduction to PASRR

Chapter 10
INTRODUCTION TO PASRR

10.1 PROGRAM BASIS AND PURPOSE

Nursing facility (NF) PreAdmission Screening/Resident Review (PASRR) is federally mandated under the Omnibus Budget Reconciliation Act of 1987, Public Law 100-203 (OBRA '87), and Public Law 101-508 (OBRA '90). [42 U.S.C. Sections 1306r(b)(3)(F) and 1306r(e)(F)] Effective January 1, 1989, PASRR is required for all individuals with MI and/or MR/DD who apply to be admitted to a Medicaid-certified NF.

Section 1919(b)(3)(F) of the Social Security Act prohibits a Medicaid certified NF from:

a) admitting or retaining any individual who has mental illness (MI) and/or mental retardation or a related condition (MR/DD), unless:
b) the State PASRR program has determined:
   1) that the individual, because of his or her physical and mental condition requires the level of services provided by a NF; and
   2) if the individual needs a NF level of services, whether the individual needs specialized services (SS) for the MI and/or MR/DD condition; or
   3) if the individual needs NF level of care but does not require specialized services, the services of less intensity than specialized services (SS) which the individual will need if admitted to a NF.

For residents who have a condition of MI and/or MR/DD, PASRR reviews and determinations must be repeated when there is a significant change in condition.

10.2 TWO-PART PROGRAM: PAS/PASRR AND RR/PASRR

The PASRR program can be divided into two parts:

a) PreAdmission Screening (PAS); and
b) Resident Review (RR).

The basic requirement for Level II assessment is the same for both parts, but the procedures differ.

10.2.1 PAS/PASRR

PreAdmission Screening (PAS) refers to the assessment and determination required PRIOR to NF admission or, if approved for a temporary admission, completed within specific time frames following admission.

To meet this requirement and avoid duplication, Indiana incorporates Indiana's PreAdmission Screening (IPAS) program into the PASRR process through its Medicaid State Plan. (See Chapters 1 through 9 for IPAS procedures.) Thus, IPAS provides the following functions for the PAS portion of the PASRR:

a) identification of persons seeking admission to Medicaid certified NFs;
b) review of and certification of need for Level II Assessment;
c) written notice to the individual of referral for Level II;
d) activating mechanism to the CMHC or D&E Team to complete a Level II Assessment;
e) provision of necessary data to evaluate and determine need for NF level of care including physical status, functional assessment (activities of daily living), alternative services and/or placement;
f) liaison between NF, family, physician, and other entities as necessary;
g) review of documentation and recommendation for placement; and
h) coordinating entity to compile case documents for submission to the State.

In addition, the federal Medicaid Manual Transmittal Number 42, issued in May, 1989 required states to interface the PASRR process with other existing or future NF preadmission screening and resident assessment procedures to the greatest extent possible.

In summary, the IPAS Agency must certify whether there is a need for Level II assessment, make referrals for Level II assessments, assure that documentation submitted to support PAS/PASRR findings is complete and accurate, including necessary signatures, credentials, and dates entered. Each IPAS/PASRR case must be reviewed by the PAS Agency prior to submission for completeness and consistency.

10.2.2 RR/PASRR

Resident Review (RR) is an evaluation which parallels the PAS process for a NF resident who has completed PAS requirements. (See Chapter 14.) RR Level II is required:

a) following a substantial change in the MI and/or MR/DD condition of any resident; or
b) yearly for certain residents determined to be MI and/or MR/DD and in need of services.

(NOTE: For PASRR purposes, change in condition means a change in the MI and/or MR/DD condition, but does not include changes of the medical condition only.)

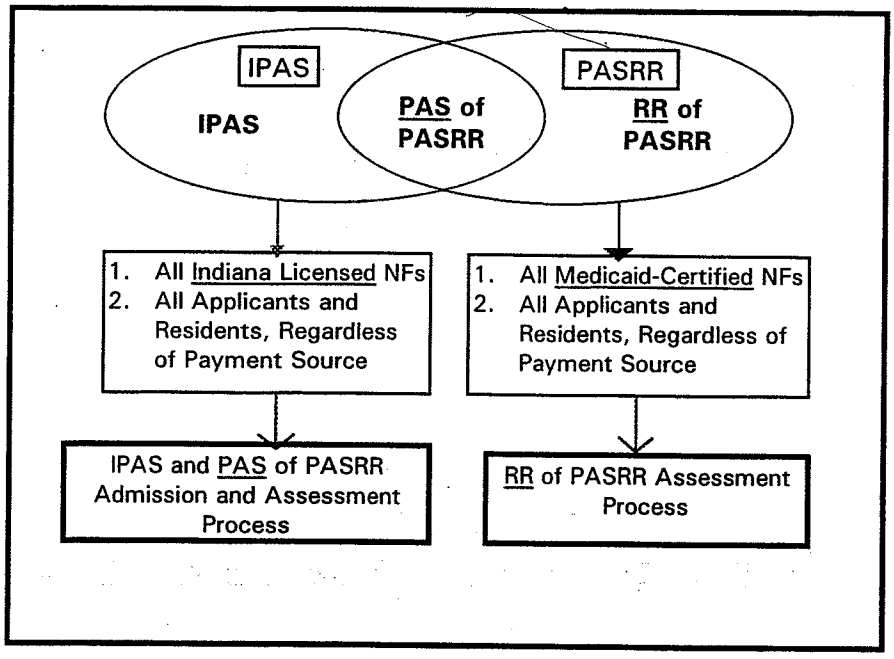
An initial RR/PASRR review of all NF residents with MI and/or MR/DD conditions who entered Medicaid-certified NFs prior to January I, I989 was required to be completed no later than April I, I990. From April I, I990 to June 30, 1997, an annual RR Level II was required for all NF residents with MI and/or MR/DD conditions. Effective July 1, 1997, some NF residents:

a) who had a prior Level II; and
b) were determined to have MI and/or MR/DD conditions; but
c) are not in need of continued mental health services;

are exempted from the annual RR requirement. At the time that they have a significant change in MI and/or MR/DD condition, they will need to have a new Level II.

NOTE: NF discharge to a community-based or other institutional setting requires that the IPAS and/or PASRR assessment process is completed again for NF admission.

INTERRELATIONSHIP OF IPAS AND PASRR (Chapter 10)



10.3 PASRR PARTICIPATION REQUIREMENTS

In general, PASRR requires:

- all Medicaid-certified NFs to participate;
- all individuals admitted to or residing in a Medicaid-certified NF to participate; and
- participation in IPAS for all new admissions who also need a Level II assessment.

10.3.1 All Medicaid-Certified NFs

ALL facilities that are Medicaid-certified to provide Medicaid reimbursable NF services are required to participate in the PASRR program, regardless of whether any residents are currently eligible for Medicaid. Every Medicaid-certified NF MUST comply with federal PASRR admission requirements, regardless of an individual's intended length of stay or source of payment: Medicare, VA contract, private-pay, insurance Medicaid, or other.

NOTE: Compliance with PASRR requirements is a contract issue of a NF's Medicaid participation agreement. To refuse to comply or ignore requirements is to jeopardize a NF's Medicaid-certification status.

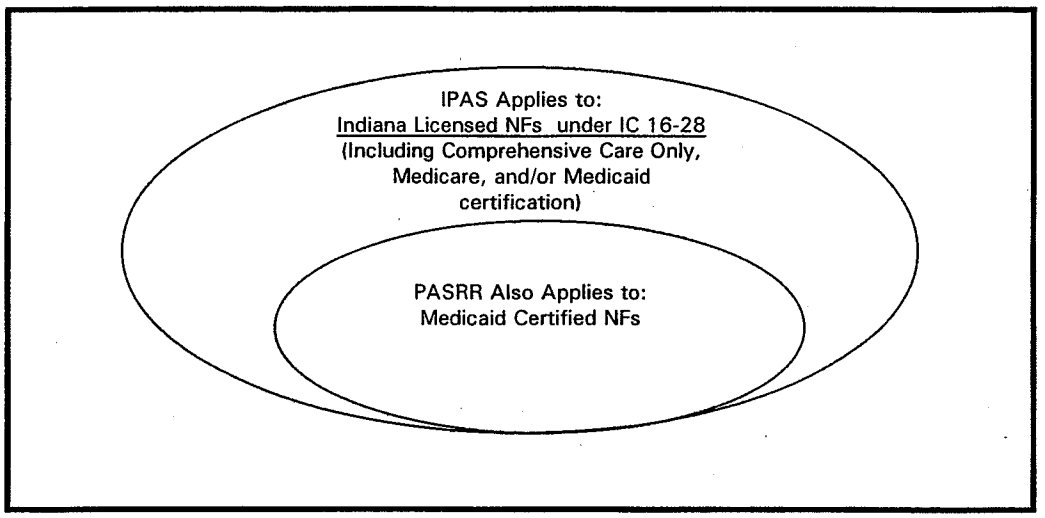
This requirement also extends to:

a) Medicaid-certified hospital-based Extended Care Facilities (ECFs), Transitional Care Units (TCUs), subacute rehabilitation units; and

b) any facility or unit holding Medicaid-certification as a nursing facility, regardless of IPAS exemption.

(Also see Chapters 2.10, 3.7, and Appendix D.)

NF Participation in IPAS and PASRR (Chapter 10)



10.3.2 All Applicants and Residents

PASRR applies to ALL individuals:

a) who seek admission to or continued placement in a Medicaid-certified NF;

b) regardless of income or resources [including those whose care will be reimbursed by Medicaid, Medicare, VA contract, insurance or any other source(s), including private-pay].

For PAS, they are required to complete a PASRR Level I, Identification Screen, and, if indicated, the PASRR Level II assessment. See Chapter 13. (For RR, see Chapter 14.)

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CHAPTER 11
LEVEL II ASSESSMENT

11.1 ASSESSMENT

11.2 ASSESSMENT COMPONENTS

11.2.1 PASRR/NF (Need for NF Level of Services)

11.2.1.1 Criteria

11.2.1.2 Data

11.2.1.3 Documentation and Process

- PAS: Medical
- RR: Medical

11.2.2 PASRR/MI

11.2.2.1 Assessment of Mental Health

11.2.2.2 Definition of MI

11.2.2.3 Designated MI Assessors

11.2.2.4 PASRR/MI Assessment Forms

11.2.2.5 Referral Termination

11.2.2.6 PASRR/MI Assessments by Hospital

11.2.3 PASRR/MR/DD or PASRR/MI/MR/DD

11.2.3.1 Definition of MR/DD

11.2.3.2 Dual Diagnosis (MI/MR/DD)

11.2.3.3 Designated PASRR/MR/DD Assessors

11.2.3.4 PASRR/MR/DD Assessment Forms

11.3 SPECIALIZED SERVICES (SS)

11.3.1 Definition of SS

11.3.2 Services of Lesser Intensity than SS

11.4 LEVEL II CASE PACKET

11.4.1 PAS and RR

11.4.2 MI Summary of Preliminary Findings

11.4.3 MI CMHC RR Referral Checklist

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CHAPTER 11
LEVEL II: ASSESSMENT

11.1 ASSESSMENT

The Level II assessment is a comprehensive evaluation to determine:

a) whether NF applicants and residents who have (or are suspected of having) a condition of MI and/or MR/DD meet the criteria for PASRR MI and/or MR/DD; and
b) whether NF level of services are needed;
c) whether MI and/or MR/DD specialized services are needed; and
d) if there is an MI and/or MR/DD condition, whether services of less intensity than specialized services are needed and what those services are.

The PASRR Level II assessment is actually composed of two (2) parts:

a) PASRR/NF is the assessment of the need for the level of medical services provided in a NF (NF Level of Services need) documented by the IPAS agency for IPAS or the NF for RR; and
b) PASRR/MI or PASRR/MR/DD or PASRR/MI/MR/DD is the assessment for a condition of MI and/or MR/DD and the need for specialized services. This part of the Level II assessment is completed by the CMHC or hospital for MI individuals, and by the D&E Team for persons with MR/DD or MI/MR/DD.

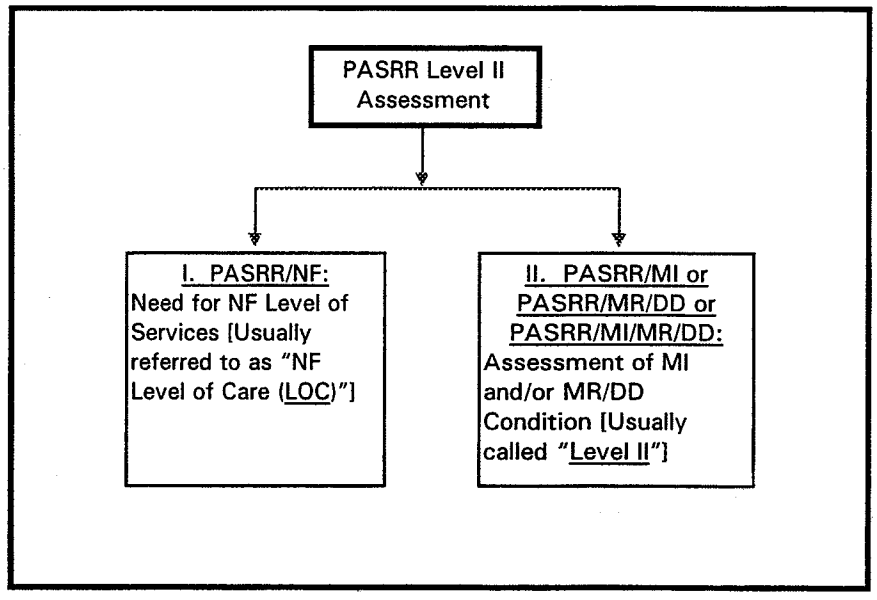
- NOTE: Both parts must be done for a Level II to be complete.

The PASRR Level II assessment and determination should provide the following results/findings:

a) "Needs/Does Not Need" NF level of services (NF LOS);
b) "Is/Is Not" MI, MR/DD or MI/MR/DD;
c) "Needs/Does Not Need" specialized services (SS);
d) if no SS are needed: "Needs/Does Not Need" services of lesser intensity than SS if admitted to a NF.

11.2 ASSESSMENT COMPONENTS

COMPONENTS OF THE LEVEL II
Chapter 13



11.2.1 PASRR/NF (Need for NF Level of Services)

The first part of the Level II assessment is the documentation of need for NF level of services. Based on the submitted documentation, the State MI or MR/DD authority (as appropriate) is required when making their determinations:

a) to determine for each applicant or resident with MI and/or MR/DD whether, due to his or her physical and mental condition, he or she requires the level of services provided by a NF; and
b) to use criteria relating to the need for NF care that is consistent with Medicaid criteria, or any supplementary criteria adopted by the State Medicaid Agency under its approved State Plan.

- For PAS - PASRR/MI Cases Only: At any point that it is determined that the individual does not meet the need for NF services criteria, the IPAS agency:
  a) may stop the Level II assessment or the Level II assessment process itself; and
  b) will confer with the State PASRR Unit to confirm the decision; and
  c) if the State PASRR Unit concurs that there is no need for NF services, will:
     1) not make a referral for a PASRR/MI Level II; or
     2) notify the CMHC that the Level II does not need to be completed; and
  d) clearly document the reason the PASRR/MI Level II was not triggered or completed in the case record;
  e) obtain a completed Inappropriate Referral form from the CMHC; and
  f) submit the case to the State PASRR/MI Unit for the final case determination (because Level II would have been required, although it was not done).

This provision does NOT apply to MR/DD or RR cases. Under MR/DD and RR, required assessments and determinations (both the NF need documentation and the Level II assessment, if required) must be completed.

If a determination to deny is overturned on appeal or reconsideration, the PASRR/MI or PASRR/MR/DD portion of the Level II assessment must be completed PRIOR to issuance of the corrected determination with the appeal or reconsideration finding.

- NOTE: If a finding of no PASRR/NF need is overturned by either reconsideration or appeal, the PASRR/MI Level II Mental Health Assessment must be completed prior to issuance of a final determination by the State mental health authority.

11.2.1.1 Criteria

The evaluator must assess:

a) whether the individual's total needs are such that they can be met in an appropriate community setting; or
b) whether the individual's total needs are such that they can be met only on an inpatient basis (including placement in a home and community-based services waiver which would offset the need for inpatient services); or
c) if inpatient care is appropriate and desired, whether the NF is an appropriate institutional setting; or
d) if inpatient care is appropriate and desired, whether the NF is inappropriate and another setting such as an ICF/MR, IMD, or psychiatric hospital is appropriate.
(Also see Chapter 13.5.)

11.2.1.2 Data

Data considered must be current and relevant to the individual's condition. Data to document the determination must be in written form. Need for NF services data must include at a minimum:

a) evaluation of physical status (e.g., diagnosis, date of onset, medications, medical history, prognosis, etc.);
b) evaluation of mental status (e.g., diagnosis, date of onset, history, likelihood that individual may be a danger to himself/herself or others, suicidal ideation, etc.); and

c) evaluation of functional impairment (activities of daily living, degree of impairment, offsets of the need for care, etc.).

11.2.1.3 Documentation and Process

The following documentation is required for the determination of need for NF services (PASRR/NF).

- PAS: Medical

For PAS, the IPAS agency is responsible to collect available medical information for the determination of need for NF level of services. (The CMHC or D&E Team will provide the other part of the PASRR Level II, namely the PASRR/MI or PASRR/MI/MR/DD assessment, for the IPAS agency to include with the case record. See Chapters 4, 13.3, and 13.4.)

The primary source of medical documentation is:

a) the Form 450B - Sections I-III, Physician Certification of Need for Long-Term Care Services [see Appendix M]; and/or
b) when available following temporary NF admission, the MDS (Minimum Data Set) of the NF's Resident Assessment; and
c) when PASRR/DD, Form 450B - Section VI (see Appendix II); and
d) for out-of-state NF residents, 30 days of nursing notes; and
e) any additional pertinent medical documents submitted to support need for NF level of services.

- NOTE: Lack of adequate and incomplete medical documentation supporting need for NF level of services is the primary reason for most denials of NF placement.

For both PAS and RR: PRIOR to submission of the case record for determination, the entity submitting the Form 450B must:

a) check the Assessment Type at the top of the document and/or enter a notation of the reason the Form 450B is being submitted;
b) assure that all applicable information is entered in "Section I-Recipient Identification;"
c) check that the name and address of the NF is entered for the NF to which the individual is being admitted or in which he or she is a resident;
d) review "Section II-Physician's Medical Evaluation" for completeness;
e) assure that the physician has certified the level of care, signed and dated the form; and
f) review and assure that any additional documentation submitted is complete.

- RR: Medical

RR cases may use the same documentation as PAS or submit other/additional medical documentation and records to determine the need for NF level of services (also see Chapter 14.):

a) Yearly RR (YRR) (Chapter 14.4) requires proof of a prior determination of need for NF services documented on:
   1) a PAS Form 4B; or
   2) a state-certified Form 450B, Physician Certification; or
   3) if NF need was first determined as a result of a prior Significant-Change Level II, for a resident under IPAS penalty, the PASRR certification form; or
   4) if need for NF level of services has never been determined, but a Level II should have been completed in the past, follow procedures for either Significant-Change RR or Missed Significant-Change RR. (See below and Chapter s 14.2 or 14.3.)
b) Significant-Change RR (Chapter 14.2) requires:
   1) same documents as YRR numbers 1 - 3, above; and also
   2) current medical information, which may include:
      i) a current MDS; and/or
      ii) a new Form 450B, Sections I-III; and/or
      iii) additional medical information attached to the prior certified Form 450B; and/or

iv) nurses notes; and/or
v) other documents.

- NOTE: For RR it is the NF's responsibility to provide sufficient documentation for the State PASRR Unit:
  a) to verify that need for NF level of services was previously made (YRR, Missed PAS, or Missed YRR); or
  b) for residents admitted under IPAS penalty who did not require PASRR, to make a determination of need for NF level of services (Significant-Change RR or Missed Significant-Change RR).

- NOTE: The CMHC or D&E Team is not required to make a judgment on the adequacy or appropriateness of documentation submitted by the NF to show medical need for NF level of services.
  a) Documentation submitted by the NF to the CMHC or D&E Team should be included with the Level II case sent to the state authority for determination.
  b) When insufficient, the State PASRR Unit will get additional documentation directly from the NF. (See Chapter 14 for RR.)
  c) When medical documentation is missing from the case record, the case will not be processed and will be returned to the CMHC or D&E Team for missing documentation.

11.2.2 PASRR/MI

The second part of the Level II process is the PASRR/MI evaluation for individuals with a condition of MI, commonly called the "Level II." The results of MI Level II mental health assessments are to be recorded on forms prescribed by the State PASRR Unit which:

a) are self-contained, because directions necessary for completion are contained on the form itself; and
b) are developed to elicit specific documentation required by federal law for the PASRR/MI determination.

Additional documentation pertinent to the case may be also appended.

11.2.2.1 Assessment of Mental Health

The PASRR/MI Level II mental health assessment must:

a) be an independent physical and mental evaluation;
b) performed by an entity other than the State mental health authority (see Chapter 11.3.1.2);
c) which reviews, at a minimum, the areas stipulated on the designated Level II: PASRR/MI Mental Health Assessment form (See Appendix Z.); and
d) provides findings which are adequately summarized, recorded, and appropriately certified on the PASRR/MI Level II form.

The PASRR/MI assessor must make an independent finding of whether the individual;

a) has a condition which meets the PASRR/MI definition of mental illness (MI) (See Chapter 13.2.1.1 and Appendix C.); and
b) needs specialized mental health services (See Chapter 13.5.1.); or
c) if specialized services are not required, needs mental health services of lesser intensity than specialized services while residing in a NF (See Chapter 13.5.2); and
d) if so, identify the mental health services to be provided in the NF.

The PASRR/MI Level II assessment must:

a) result in a determination of the AXIS I, II and III diagnoses, independent of those diagnoses recorded on the chart or other medical records; and
b) document and support these findings on the Level II form itself.

- NOTE: When more than one (1) Axis I diagnoses is determined, they must be ranked in order of predominance with the principal/primary condition listed first.

11.2.2.2 Definition of Mental Illness

See Appendix C for the full definition of mental illness (MI).

In brief, an individual is considered to have a condition of mental illness if he or she:

a) has a current primary or secondary diagnosis of a major mental illness (as defined in DSM-IV or the current Diagnostic and Statistical Manual) limited to the following: schizophrenic, schizoaffective, mood (bipolar and major depressive type), paranoid or delusional, panic or other severe anxiety disorder; somatoform or paranoid disorder; personality disorder; atypical psychosis or other psychotic disorder (not otherwise specified); or another mental disorder that may lead to a chronic disability; and
b) does not have a concurrent PRIMARY (PRINCIPAL) diagnosis of documentable dementia (including Alzheimer's Disease or related disorder).

- NOTE: For purposes of the PASRR program, a diagnosis of alcoholism (ETOH) without any indicator of a major mental illness as defined above will not require a PASRR/MI Level II. Behavioral problems due to alcoholism or dementia do not trigger a Level II, but should be clearly identified to a NF which is considering admission so the NF can determine whether it can meet the individual's needs.

The exception to this criteria is an individual who is an inpatient in a state psychiatric hospital. (See Chapter 10.3.5.)

An IPAS agency should:

a) always thoroughly question and explore requests for admission from inpatient psychiatric units;
b) to determine and assure, as much as possible, that there is not a co-existing diagnosis of major mental illness (or for dementia patients, a diagnosis of serious MI which is primary to the dementia);
c) before certifying on the bottom of the Level I that Level II is not needed.

11.2.2.3 Designated MI Assessors

Public Law 101-508, Section 4801(b)(1-8), referred to as OBRA '90, restricts entities that may conduct PASRR assessments and determinations. Under U.S.C. 1396r, Section 1919(b)(3)(F)(iii) states: "A state mental health authority and a State mental retardation or developmental disability authority may not delegate (by subcontract or otherwise) their responsibilities under this paragraph to a nursing facility (or to an entity that has a direct or indirect affiliation or relationship with such a facility)."

42 CFR 483.106(e)(3) further clarifies this provision: "The evaluation of individuals with MI cannot be delegated by the State mental health authority because it does not have responsibility for this function. A person or entity other than the State mental health authority must perform the evaluation function. In designating an independent person or entity to perform MI evaluations, the Sate must not use a NF or an entity that has a direct or indirect affiliation or relationship with a NF."

Interpretative guidelines published in the Federal Register dated November 30, 1992 provides the following clarifications and instructions:

> "Individual physicians or mental health professionals (unless they are owners, operators, or employees of the NF) would not be precluded from performing those portions of the PASRR evaluations which they are qualified to perform....local boards which own or operate public nursing facilities (NFs) are barred from PASRR evaluations."

Each entity completing a PASRR/MI Level II assessment must review and assess its activities in this regard to assure that this requirement is met.

- NOTE: This requirement does not apply to completion of the PASRR Level I: Identification Screen. As indicated on the Level I form, the physician, hospital discharge planner, NF, case

manager, or other professional who knows or is able to ascertain sufficient knowledge of the applicant's condition, may complete the eight questions (Level I) on this specific form. (See Chapter 2.5.)

Under Indiana's PASRR program, only the following entities are authorized to conduct PASRR evaluations:

- CMHC: The Indiana licensed Community Mental Health Centers (CMHC) are the agencies authorized to complete PASRR/MI Level II Mental Health Assessments for PAS and RR as follows:
  a) the CMHC serving the area in which the individual is located will complete the Level II assessment; except that for
  b) residents of a State Psychiatric Hospital, the CMHC which has gatekeeper responsibility for the individual has primary responsibility for completion of the PAS/PASRR Level II.

  The gatekeeper CMHC:
  a) has the option to defer completion of the Level II to the closer CMHC which serves the locality of the State Psychiatric Hospital, e.g., when geographic distance makes completion of a Level II impractical and/or cost prohibitive;
  b) must work out details of the deferral with the local CMHC to assure that the federal PAS timeliness requirement is met; and
  c) must assure that the referring IPAS agency is notified, in writing, when a gatekeeper CMHC which is not also the local CMHC is responsible for the Level II.

- Indiana Hospitals: Under specific circumstances, a hospital is also authorized to conduct a PASRR/MI Level II Mental Health Assessment. All requirements for the Level II Assessment must be met, including:
  a) the assessed individual is receiving care in the hospital's acute care inpatient bed and needs transfer into a Medicaid-certified non-acute care (nursing facility) bed or unit; and
  b) all areas of the PASRR/MI Level II Mental Health Assessment are:
     1. thoroughly completed, meeting PASRR/MI standards;
     2. signed and dated by a certified social worker on page 2; and
     3. certified by a board-certified or board-eligible psychiatrist on page 4; AND
  c) the individual is not being admitted into a non-acute bed in which the hospital has an interest or affiliation.

11.2.2.4 PASRR/MI Assessment Forms

- The Assessment of Mental Health form (State Form 43064/BAIS 0036) (see Appendix Z) is the established format for documenting the PASRR/MI mental health portion of the Level II.

- The Inappropriate Referral for Level II Assessment form (State Form 47180/BAIS 0028) (see Appendix BB) may be completed and issued by a CMHC in lieu of the PASRR/MI Level II assessment. (See Chapter 13.3.2.)

- The Summary of Preliminary Findings and Recommendations of PASRR/MI Level II Mental Health Assessment form (State Form 47183/BAIS 0030) (See Appendix AA):
  a) must be completed by the assessor as soon as an assessment is done;
  b) will record the Level II findings and recommendations prior to review and certification by the psychiatrist;
  c) meets federal requirements to provide the assessment findings to the resident, his or her guardian or legal representative, and the NF;
  d) provides a format for the assessor's exit interview with the NF; and
  e) should be placed on the resident's chart until the case packet with the final determination is received:
     1) as proof that the Level II assessment was completed; and
     2) for utilization by the NF for patient care planning.

11.2.2.5 PASRR/MI Referral Termination

At any point that a PASRR Level II is terminated prior to completion, the CMHC must document the reason that it was not completed on the Level II "Inappropriate Referral" form (see Appendix BB).

- Use of the "Inappropriate Referral" form is reserved for the CMHC only. When appropriate, the completed "Inappropriate Referral" will be processed in lieu of a PASRR/MI Level II. It may be used to document:
  a) why a required PASRR/MI Level II is not completed;
  b) why a referral for PASRR/MI Level II from the IPAS agency is deemed to be unnecessary; and
  c) situations when PASRR/MI Level II is deferred until a later date, including an explanation of the individual's condition and a caveat holding the NF responsible to monitor the resident and make referral for Level II as soon as the resident can participate. (For example, an individual in delirium or a comatose state cannot be assessed until the condition clears or ameliorates enough for the individual to participate in the interview.)

11.2.2.5 PASRR/MI Assessments by Hospital

To expedite discharge and avoid delays, an acute care hospital may choose to complete the PASRR/MI Level II assessment.

As part of its discharge planning, each hospital:

a) should identify patients at risk of possible NF placement as soon as possible following admission;
b) through an "early warning system" implemented for those inpatients who will require IPAS and/or PASRR assessment.

To complete the Level II, the hospital should follow directions on the Level II: Mental Health Assessment form itself and this Manual.

- For PAS, the hospital should:
  a) FAX the Level II and other IPAS documents directly to the IPAS agency; and
  b) immediately mail or deliver the originals to the IPAS agency; and
  c) provide copies to the chosen NF.

- For RR, the hospital will need to identify whether PASRR Level II is needed prior to or after NF readmission. (See Chapter 14.1.4.2.)

When Level II is required prior to return to a NF, the hospital may:

a) complete the PASRR/MI Level II; or
b) make a referral directly to (or have the NF contact) the local CMHC to complete the Level II. (See Chapter 14.2.4 for procedures to notify the CMHC to do a Level II).

If the hospital completes the RR PASRR/MI Level II, it should:

a) assure that the case documents include, at a minimum:
   1) a cover sheet or letter of explanation;
   2) a new 450B Physician Certification for Long-Term Care and/or other medical documentation to support need for NF level of services;
   3) the PASRR/MI Level II Assessment of Mental Health (completed by the hospital);
   4) a copy of the Form PAS 4B or a "state-certified" Form 450B, Physician Certification (obtained from the NF from which the individual was admitted); and
   5) other documentation deemed pertinent and necessary; and
b) FAX the Level II assessment and other required documents directly to the State PASRR/MI Unit.

THE HOSPITAL MUST IMMEDIATELY MAIL THE CASE HARD COPIES DIRECTLY TO THE DESIGNATED NF.

- NOTE: Failure of the hospital to send the case hard copies to the NF may jeopardize future acceptance of faxed cases from that hospital. Furthermore, the NF may be in jeopardy of denial of reimbursement and in noncompliance with program requirements.

Upon receipt of a faxed PASRR/MI RR case, the State PASRR Unit will:
a) immediately review the case record; and
b) return FAX the RR determination to the NF designated by the hospital. (Sometimes verbal approval will be given by telephone pending issuance of the determination form.)

When the hospital also wants a copy of the determination, it should make a clear note to that effect on its FAX cover sheet, including the hospital's FAX number.

11.2.3 PASRR/MR/DD or PASRR/MI/MR/DD

For individuals with a condition of MR/DD and MI/MR/DD, the second part of the evaluation is the PASRR/MR/DD or PASRR/MI/MR/DD evaluation.

ONLY the contracted Diagnosis and Evaluation (D&E) Teams are authorized to perform the PASRR/DD Level II.

When collateral information appears to support that the individual is not MR/DD, the IPAS agency should:
a) provide this information to the D&E Team when the referral for Level II is made;
b) including information about completion of school, an independent work history, raising a family, or other life accomplishments not usually ascribed to individuals with MR/DD.

It may help the D&E Team expedite a determination of whether the individual meets the criteria for developmental disability.

11.2.3.1 Definition of MR/DD

For purposes of PASRR, a suspected condition of MR/DD or MI/MR/DD always requires review by the BDDS Field Office to determine whether an individual meets the qualifications for having a condition of developmental disability. <u>This certification must be documented in writing.</u>

An individual is considered to have a condition of mental retardation/developmental disability if he or she:
a) has a severe, chronic disability attributable to mental retardation, cerebral palsy, epilepsy, autism, or a condition, other than mental illness, closely related to mental retardation in that the impairment of general intellectual functioning or adaptive behavior are similar to that of mental retardation; and
b) the condition manifested itself prior to age 22, is likely to continue indefinitely, and requires that the person have 24-hour supervision; and
c) as a result of the condition, the person has substantial functional limitations in three or more of the following major life areas: self care, understanding and use of language, learning, mobility, self direction, capacity for independent living.

When an individual is:
a) determined to be <u>not</u> MR/DD; but
b) has or is suspected of having a condition of serious MI;

referral for PASRR/MI Level II by the CMHC must be done.

- NOTE: The case record must include the MR/DD certification that the individual is <u>not</u> MR/DD and the NF should maintain it on the resident's chart.

11.2.3.2 Dual Diagnosis (MI/MR/DD)

An individual is considered to have a dual diagnosis if he or she has both MI and MR/DD. The MR/DD condition is always considered to be the primary condition for PASRR purposes. These individuals must always be referred to the D&E Team for the MR/DD Level II.

11.2.3.3 Designated MR/DD Assessors

Federal law and regulations cited in Chapter 12.2.2.4 also apply to assessors for MR/DD and/or MI/MR/DD assessments and determinations.

In Indiana the designated and contracted entity to perform MR/DD evaluations is the local D&E Team working with the local BDDS Field Services offices.

11.2.3.4 PASRR/MR/DD Assessment Forms

In addition to the forms required for IPAS, the PASRR/MR/DD portion of the Level II requires the following forms for PAS and for RR.

- The "Pre-Admission Screening/Resident Review Certification for Nursing Facility Services" (State Form 46922(R/2-98)/BAIS 0024) provides a summary of the PASRR/MR/DD determination certification. It must accompany the other documents listed here and will usually be placed on top.

- A multi-page electronic form, titled "Case Analysis: Preadmission Screening" or "Case Analysis: Resident Review," is the PASRR/MR/DD portion of the Level II. The number of pages may vary according to the individual's condition and identified needs.

- The "Certification By Physician for Long-Term Care Services and Physical Examination for PASRR Level II" (State Form 45278(2/92)Form 450B/PASARR2A - Section VI) provides supplemental medical information required by 42 CFR 483.136.

- "Definition of Specialized Services for PAS/ARR" (State Form 46921(3/95)/BAIS 0023) is an optional form used to record the Level II service(s) findings. If the form is not used, the information, which it would have identified, must be recorded elsewhere in the D&E assessment.

11.3 SPECIALIZED SERVICES (SS)

Specialized Services are intensive services identified through the Level II Assessment that are needed to address certain identified needs related to an individual's condition of MI and/or MR/DD. These services are of a duration and/or intensity that they are not typically provided within or by a nursing facility. Listed below is the definition of PASRR Specialized Services as defined in Indiana's Medicaid State Plan.

11.3.1 Definition of SS

As defined in the Indiana State Plan Amendment 1-1-93 under Title XIX of the Social Security Act, "specialized services are those services identified through the Level II Assessment which are required to address the identified needs related to the person's developmental disability and/or mental illness...." See the back of Appendix C.)

NOTE: See Chapter 16 for directions and conditions under which the "30-month" rule and choice of setting in which to receive Specialized Services apply. Very specific criteria must be followed before ascribing the PASRR 30-month parameters.

For MI: Specialized services are defined as the implementation of an individualized plan of care developed under and supervised by a physician, provided by a physician and other qualified mental health professionals, that prescribes specific therapies and activities for the treatment of persons who are experiencing an acute episode of severe mental illness, which necessitates supervision by trained mental health personnel. A nursing facility resident with mental illness who requires specialized services shall be considered to be eligible for the level of services provided in an institution for mental diseases (IMD) or an inpatient psychiatric hospital.

For MR/DD: Specialized services for MR/DD may include, but are not limited to, short term inpatient psychiatric care, long term psychiatric care, supported employment, supported employment follow-along, sheltered work, vocational evaluation, work adjustment training, vocational skills training and job placement.

11.3.2 Services of Lesser Intensity than SS

Specialized Rehabilitative Services are those services identified through the Level II assessment which are required to address one's identified needs as a result of their developmental disability and/or mental

illness. These services are less intensive than "Specialized Services" and can be provided in a NF or under contract with outside sources.

These services are less intensive than "specialized services" and must be provided by the NF to all residents who need such services. They are identified through the Level II assessment for MI and/or MR/DD and specified through the final determination. These services may be provided in the NF by qualified NF staff or under contract with outside resources.

11.4 LEVEL II CASE PACKET

For each PASRR Level II, the CMHC or D&E Team/BDDS Office will prepare a packet of case documents. The case packet will be distributed as follows.

11.4.1 PAS and RR

- For PAS (See Chapter 13 for a list of documents.):

a) PASRR/MI: The CMHC will provide the case packet to the local IPAS agency; and
b) PASRR/MR/DD: The D&E Team will provide the case packet to the appropriate BDDS Office, which will process and forward it to the local IPAS agency.

- For RR (See Chapter 14 for a list of documents.):

c) PASRR/MI: The ~~CMHC will send the case packet to the State PASRR Unit; and~~
d) PASRR/MR/DD: The D&E Team will send the case packet to the local BDDS Field Office.

- NOTE: For RR, the CMHC or D&E Team is not required to make a judgment on the adequacy or appropriateness of documentation submitted by the NF to support need for NF level of services. When documentation is not sufficient, the State PASRR Unit will contact the NF to resolve discrepancies or get additional information.

There may be private-pay residents who have never had need for NF level of services determined by Medicaid, IPAS or PASRR because:

a) they were admitted under IPAS penalty for refusal to participate; and/or
b) have had a significant-change in condition for MI following NF admission; and/or
c) were missed under IPAS; and
d) have neither a Form PAS 4B or State-certified Form 450B.

The CMHC or D&E Team assessor should contact the State PASRR Unit to determine how to meet this documentation need for the case packet.

- NOTE: "Current" means that the resident's condition on which the document is based remains the same and has not changed.

11.4.2 MI Summary of Preliminary Findings

At the conclusion of each MI Level II mental health assessment, the CMHC assessor will:

a) explain the findings to the individual;
b) complete the "Summary of Preliminary Findings and Recommendations of PASRR/MI Level II Mental Health Assessment" (See Appendix AA.);
c) give a copy of the Summary of Preliminary Findings and Recommendations to the NF resident (and, if indicated, family, guardian, or personal representative); and
d) give a copy to the NF at the exit interview.

The CMHC assessor will use it to explain the assessment findings and answer questions.

The NF will:

a) provide a copy to the NF resident, if needed;
b) use the Summary of Preliminary Findings and Recommendations for resident care planning; and
c) place it on the resident's chart until the final MI RR case packet is received.

11.4.3 MI CMHC RR Referral Checklist

For MI, the CMHC RR Referral Checklist form will assist the CMHC to document planning and scheduling activities for Yearly RRs, collect essential tracking data, and list cases submitted to the

State PASRR Unit. Information on the Checklist form also provides data essential for initial state entry. The CMHC will:

a) complete the CMHC RR Referral Checklist form (Appendix EE) [except Column #12];

- NOTE: In Part 4, check status by substituting "Yearly" for "Routine," and "Significant-Change" for "Non-Routine". The date for "Routine" should be entered as "N/A."

b) obtain the date of the most recent Level II assessment, if one has been done, and enter the date of the psychiatrist's signature in Column #9. This information should be available from the CMHC files or from the NF chart;

- NOTE: If no record of a prior Level II can be found, the CMHC should make an explanatory notation in Checklist Column #9, "Date Last L-II Assmt," specifying the reason: "Prior Level II Not Required," "Prior Level II Required and Completed - But Missing," "Prior Level II Required - But Never Referred or Completed," "Resident Transferred, But NF Did Not Notify CMHC." If none of these apply, or more explanation is needed, the CMHC should enter a brief explanatory phrase as necessary.

c) after the Level II assessment is completed, enter the date of the psychiatrist's signature in Column #12;

- NOTE: A comparison of Columns #9 and #12 on the CMHC RR Referral Checklist will verify whether the RR time limit is in compliance;

d) attach a copy of the CMHC RR Checklist to the RR case(s) prior to submission to the State PASRR Unit.

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CHAPTER 12
PASRR DETERMINATIONS AND APPEALS

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CHAPTER 12
PASRR DETERMINATIONS AND APPEALS

Based on Level II findings contained in the PAS and RR case documentation materials submitted to the State for review and determination, the State MI or MR/DD authority will issue a determination of:

a) whether an individual requires the level of services provided by a NF;
b) whether specialized services are needed; and
c) if NF is approved, whether MI and/or MR/DD services of lesser intensity than specialized services are needed.

12.1 PASRR DETERMINATION CRITERIA

At a minimum, the PASRR Level II assessment process will result in the following findings:

a) the individual does/does not have a need for NF level of services;
b) the individual has/does not have a condition of MI and/or MR/DD as defined for PASRR purposes;
c) the individual does/does not need specialized services as defined for PASRR purposes; and
d) the individual does/does not need services of a lesser intensity for his/her condition of MI and/or MRDD, specifying the particular service needs.

12.1.1 Determination Authorities

The following entities are authorized to make the final PASRR determination:

a) for all PAS and MI-RR, the State PASRR Unit will review Level II case packets and make the final determination; and
b) for MR/DD-RR and MI/MR/DD-RR cases, the local D&E Team will review Level II case packets and make the final determination.

12.1.2 Appropriate Placement

Placement of an individual with MI and/or MR/DD in a NF is considered appropriate only when:

a) the individual's needs are such that he or she meets the minimum standards for NF admission or residence; and
b) the individual's needs for treatment do not exceed the level of services which can be delivered in the NF to which the individual is admitted.

Determinations regarding appropriate placement will be made:

a) on an individual basis, taking into account the needs of the individual; and
b) following application of the criteria:
    1) under 450 IAC 1-3-1 and 1-3-2 for MI; and
    2) under 450 IAC 1-3-1 for MR/DD.

A caveat may be entered on the IPAS 4B Determination Form concerning placement needs when an individual requires specific service consideration, for example, care in an Alzheimer's Unit, problem behaviors, or monitoring for possible suicidal ideation.

12.1.3 Placement Categories

All determinations, both categorical and final, will be recorded in the resident's NF record.

- **Categorical Determination**

Categorical determinations are those decisions which take into account that certain diagnoses, levels of severity of illness, or need for a particular service clearly indicate that admission to or residence in a NF is normally needed, and that provision of specialized services is not normally needed. Advance group categorical determinations include Exempted Hospital Discharge, Respite Care and APS. (See Chapter 13.)

The NF will maintain copies of the documents authorizing temporary admission on the individual's chart:

a) Level I;

b) PASRR Categorical Determination for Respite and APS (Appendices U and W) form; and
c) Application for Long-Term Care Services.

NOTE: Requirements for these categorical determinations differ from the categories of temporary admission under Indiana's IPAS program. They are more restrictive and require authorization on specific PASRR forms.

- Individualized Determinations

Individualized determinations are those decisions based on more extensive individualized evaluations. These individualized determinations include (a) the evaluation and findings of need for NF level of services (PASRR/NF); and (b) whether an individual with MI (PASRR/MI) and/or MR/DD (PASRR/MR/DD) requires specialized services.

- Final Determination

The PASRR final determination for individuals with MI will be made:
a) by the designated State mental health authority (State PASRR Unit); and
b) be based on an independent physical and mental evaluation performed by a person or entity other than the designated State mental health authority.

The PASRR final determination for individuals with MR/DD will be made by the designated State MR/DD authority (State PASRR Unit), without any requirement for independent evaluation other than the D&E Team.

The final determination is:
a) (or PAS) included on the PAS/PASRR Assessment Determination Form 4B; and
b) (for PASRR/MI RR) issued in the form of an RR Determination Letter; and
c) (for PASRR/MR/DD RR) issued as a certification form and an RR Determination Letter.

NOTE: The NF should maintain all IPAS/PASRR documentation in the same section of the resident's chart, including, but not limited to, the IPAS application, Level I, Level II, other assessment documents, PAS 4B, RR Determination Letter, etc.

12.1.3.1 PAS/PASRR Determinations

Can be admitted to a NF if the applicant has been found:
1) to meet the requirements of need for NF level of services under 450 IAC 1-3-1 or 1-3-2 (See Chapter 4.6.1.); and
2) does not require specialized services (See Chapter 13.5.).

Cannot be admitted to a NF: the applicant has been determined to NOT meet the requirements for NF need for care, regardless of the need for specialized services.

12.1.3.2 RR/PASRR Determinations

a) Can be considered appropriate for continued placement in a NF when the resident:
   1) has been determined to meet the need for NF level of services; and
   2) does not need specialized services;
b) Cannot be considered appropriate for continued placement in a NF and will be discharged to an appropriate setting when the resident:
   1) does NOT have a need for NF care; and
   2) has resided in a NF for less than 30 consecutive months (short-term residents);
   3) regardless of the need for specialized services.
c) Cannot be considered appropriate for continued placement in a NF and will be discharged, regardless of the length of his or her stay (short or long-term residents), when the resident:
   1) does NOT have a need for NF level of services; and
   2) does NOT require specialized services.
d) For MR/DD residents, may choose to remain in the NF even though the placement would otherwise be inappropriate when the resident:
   1) does NOT have a need for NF level of services;

2) but DOES require specialized services; and
3) has continuously resided in a NF for at least 30 consecutive months before the date of determination inappropriate (long-term resident). The resident may choose to continue to reside in the facility and receive specialized services, or to receive specialized services in an alternative appropriate institutional or noninstitutional setting. (NOTE: For persons meeting this requirement who choose to remain in the NF setting, specialized services will be provided in the NF.)

e) For MI residents, specialized services are equivalent to provision of inpatient psychiatric care and are not typically provided within or by a NF due to the duration and/or intensity of the MI specialized services.

12.1.4 Level II and MDS

Federal regulations require that:

a) the CMHC or D&E Team review the NF Minimum Data Set and Resident Assessment/ (MDS and RA) as part of the PASRR Level II assessment; and
b) the NF utilize the PASRR Level II with the resident's individualized plan of care for residents with MI and/or MR/DD conditions.

Combining these two processes will produce a more comprehensive, multidisciplinary approach to the individual's care plan. It is the NF's responsibility to assure that the Level II and the MDS assessments are used interactively. The MDS is updated quarterly or with a significant change in the resident's condition or treatment.

The CMHC or D&E Team should:

a) review and utilize information and documentation available at the NF, including the RA/MDS, for purposes of the Level II assessment;
b) bring conflicting or inaccurate information to the attention of the NF and discuss it with them.

NOTE: The NF, with the attending physician and/or NF medical director, will need to reconcile discrepancies between the NF's charted MI diagnosis and the diagnosis determined by the Level II assessment. The physician should feel free to contact the Level II assessor or psychiatrist at the CMHC to discuss questions or concerns.

12.1.5 Level II Termination

- For PAS: The PAS/PASRR case:

a) may be terminated at any point it has been determined that there is no need for NF level of services; and
b) for applicants who are determined to not need NF level of services, the specialized services determination does not need to be made. (See Chapter 5.2.)

NOTE: For MR/DD cases, however, there must always be a finding of both need for NF level of services and need for specialized services.

- For RR: An RR/PASRR case may NOT be terminated as soon as it is found that there is no need for NF care. The determination for RR must always include both parts:

a) a determination of need for NF level of services; and
b) a finding of need for specialized services.

Cases may also be terminated early due to, but not limited to, the following reasons:

a) death prior to determination;
b) transfer to another NF;
c) written voluntary withdrawal of the application for NF admission; or
d) refusal to cooperate in a timely manner (within the legally defined time frames for case processing and determination).

NOTE: Regulations state that a Medicaid-certified NF must not admit or retain any individual who requires PASRR Level II, but has not had one. Therefore, an individual cannot refuse Level II and remain in a NF. When an individual or his representative refuses to cooperate in Level II, the Level II assessor